De-Mentes

In collaboration with:

más que bipolar



THE RIGHT TO LIVE IN THE COMMUNITY:

Progress and setbacks on the path toward deinstitutionalization in Peru

RESEARCH REPORT:

The Right to Live in the Community: Progress and Setbacks on the Path Toward Deinstitutionalization in Peru

De-Mentes Perú
https://dementes.org.pe/
@dementespe
Tel. (+51) 992-222-043

In collaboration with:

Más Que Bipolar
@masquebipolar

Lima, October 2026.

Authors: Lucero Andaluz Llerena,
Carolina Díaz Pimentel and Ellen Mayorca Huamán

Research coordination, editing, and publication:
Lucero Andaluz Llerena

Design and layout: Rebeca Cabrejo Chávez

Glossary

Community mental health centers:

Under Peru's regulatory framework, these specialized health facilities provide comprehensive mental health and addiction care through a community-based approach. Their work includes mental health promotion and prevention, as well as outpatient care for psychosocial and mental health problems. They were established as an alternative to institutionalization.

Community-based supports:

The formal and informal services, resources, and networks available within a community that enable people to go about their daily lives, exercise their rights, make decisions, and participate in society.

Community-based approach to mental health:

An approach that places people and communities at the center of support and services. It promotes and protects mental health and supports the well-being of people experiencing mental health problems, with their active participation in care and recovery.

Deinstitutionalization:

A process of transforming the mental health system, replacing a model based on psychiatric hospitals and long-stay institutions with a network of person-centered community services and community-based supports that respect people's rights and autonomy. It aims to ensure that everyone who needs mental health care can exercise their right to live in the community, receive support for independent living, participate fully in society, and access comprehensive, ongoing treatment close to where they live.

Independent living:

The right of people to make decisions about their own lives, choose where and with whom to live, and have the support they need to participate in the community on an equal basis with others.

Institutionalization:

For the purposes of this report, the process through which a person enters and remains in a mental health institution, particularly for medium- or long-term inpatient care or residential placement. This separates them from their community and may restrict their autonomy, decision-making, and participation in community life.

Lived experience:

Knowledge gained from having personally experienced a situation. In mental health, this refers to the knowledge and perspectives people gain from their own experiences of mental health and of accessing mental health services. It includes the first-hand experiences of people with psychosocial disabilities or people who have experienced mental health problems and, in some contexts, those of people who have supported or cared for family members or others close to them. Lived experience is a form of knowledge and expertise essential to the design and implementation of mental health policies and interventions.

Mental health problems:

Throughout this report, we use this term to refer to any diagnosis or difficulty affecting a person's mental health. We use it as an alternative to "mental disorders" and similar terms to adopt a less pathologizing approach that recognizes the diversity of mental health experiences.

Mental health institution:

In this report, a facility providing mental health care through medium- or long-term inpatient care or residential placement. This includes psychiatric hospitals, asylums, and other residential or institutional facilities whose structure separates people from their communities, restricts their autonomy, and limits their participation in community life

Mental health:

A state of well-being that enables us to cope with adverse situations, develop our abilities, learn, work, and contribute to our community. It is a dynamic and non-linear state that is constantly influenced by a range of social determinants throughout our lives.

List of abbreviations

Abbreviation	Full name
CRPD	Convention on the Rights of Persons with Disabilities
CRPD Committe	Committee on the Rights of Persons with Disabilities
CSMC	Community Mental Health Center (Centro de Salud Mental Comunitaria)
DSAME	Mental Health Directorate of the Ministry of Health of Peru (Dirección de Salud Mental)
HP	Supported Homes (Hogares Protegidos)
IACHR	Inter-American Commission on Human Rights
MEF	Ministry of Economy and Finance of Peru (Ministerio de Economía y Finanzas)
MINSA	Ministry of Health of Peru (Ministerio de Salud)
OGPPM	General Office of Planning, Budget, and Modernization of the Ministry of Health of Peru (Oficina General de Planeamiento, Presupuesto y Modernización)
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAHO	Pan American Health Organization
PIM	Revised Institutional Budget (Presupuesto Institucional Modificado)
PP	Budget Program (Programa Presupuestal)
PpR	Results-Based Budget (Presupuesto por Resultados)
UHSMA	Mental Health and Addiction Inpatient Units (Unidades de Hospitalización de Salud Mental y Adicciones)
UN	United Nations
UNDP	United Nations Development Programme
WHO	World Health Organization

Table of contents

Executive summary 8

1. Introduction 9

2. Methodology 11

2.1 Data collection 11
2.2 Ethical considerations 13

3. What is deinstitutionalization and why does it matter? 15

3.1 Deinstitutionalization and the community-based model of care 15
3.1.1. Lessons from international experience 17
3.1.1.1. Italy and the Trieste experience 18
3.1.1.2. Brazil and the expansion of alternatives to hospital care 18
3.1.1.3 The United Kingdom and life after discharge 19
3.2 Global human rights standards 19
3.2.1. The right to live in the community 19
3.2.2. Autonomy and legal capacity 20
3.2.3. Informed consent and decisions in care 20
3.2.4. Non-discrimination and accessibility 21
3.3 Global progress and challenges in deinstitutionalization 21
3.3.1. QualityRights: toward rights-based mental health services 22
3.3.2. Lived experience as essential knowledge 22
3.3.3. The WHO practical guide to deinstitutionalization 23

4. The path toward deinstitutionalization in Peru 26

4.1 From the institutional model to the community-based model 26
4.2 Progress and challenges of the mental health reform 28

Table of contents

5. Voices of people with lived experience of institutionalization 35

5.1 Decision or imposition? Institutionalization and informed consent 35
5.2 Living in custody: the loss of autonomy during institutionalization 38
5.3 When treatment and medication become a form of control 40
5.4 Dignified treatment? Power dynamics, coercion, and mistreatment 42
5.5 Institutionalization as a response to a system without alternatives 45
5.6 What needs to change? Proposals informed by lived experience 47

6. . The current situation: threats to deinstitutionalization in Peru 52

6.1 The slowdown in the community-based reform and its contributing factors 52
6.2 Relevant political and legislative developments 53
6.3 What is at stake 56

7. Conclusions 57

8. Recommendations 59

8.1 Central and Regional Governments 59
8.2 Congress and Senate 60
8.3 Civil society, academia, and international cooperation partners 61
8.4 The public 61

9. References 62

Executive summary

This study analyzes the progress, gaps, and setbacks in the transformation of the mental health care model in Peru from a human rights-based approach and in dialogue with the international standards and commitments undertaken by the Peruvian State.

Although the country has made progress in developing community mental health services, challenges persist in their implementation. Health system fragmentation, gaps in continuity of care, limited public access to information, and inadequate coordination of community-based support services hinder the effective exercise of the right to live in the community. Likewise, the testimonies gathered from people with lived experience of institutionalization reveal the persistence of abuse, restrictions on autonomy, and coercive practices that violate rights and can deepen suffering and emotional distress rather than contribute to recovery and social inclusion. These findings show that transforming the model of care remains an outstanding challenge and that the development of community-based services alone does not guarantee deinstitutionalization or the effective exercise of rights.

Overall, the study provides robust evidence of significant gaps between mental health policy and practice in Peru, as well as growing risks of setbacks in the community-based mental health reform. In response to these challenges, the report sets out recommendations for the public institutions responsible for mental health policy, the legislative branch, civil society, and the wider public. These recommendations aim to strengthen the implementation of the community-based model of mental health care, prevent human rights violations, ensure the meaningful participation of people with lived experience, and secure access to community-based support that enables people to fully exercise their right to live in the community.



1. Introduction

Mental health is a state of well-being that enables us to cope with life's adversities, develop our abilities, learn, work, and contribute to our community (World Health Organization [WHO], 2026a). This definition helps us understand mental health beyond an exclusively clinical, individual perspective. It recognizes the profound influence of the conditions in which we are born, grow, live, and age, including economic, environmental, sociocultural, and demographic factors (Patel et al., 2018).

Communities therefore play a fundamental role in promoting and protecting mental health and providing care. They offer relationships, support networks, opportunities, and resources that help people develop and cope with adversity. Living in the community is both a right and an essential condition for mental health care.

Yet for centuries, mental health care has been organized around the segregation and isolation of people. Today, **more than 8.4 million people worldwide live in mental health institutions**, including asylums, hospitals, and other facilities (United for Global Mental Health, 2025). In much of the world, specialized psychiatric hospitals also continue to receive the largest share of national mental health budgets (WHO, 2025a).

In low- and middle-income countries such as Peru, one in five people admitted to these institutions stays for more than a year, and one in seven for more than five years (WHO, 2025a). In Peru, there is evidence of people who have spent more than 60 years in institutions such as Víctor Larco Herrera Hospital, the Honorio Delgado–Hideyo Noguchi National Institute of Mental Health, and Hermilio Valdizán Hospital (Berríos, 2023).

Institutionalizing people who experience mental health problems (that is, isolating them for extended periods) in many cases violates several articles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Involuntary hospitalization, coercive practices, and other forms of human rights violations are common in mental health institutions that operate behind closed doors (WHO & Office of the United Nations High Commissioner for Human Rights [OHCHR], 2023; Sugiura et al., 2020). These practices can profoundly affect people's mental health and well-being rather than contributing to their recovery (Porsdam et al., 2016).

In response, **recent decades have seen a gradual shift toward community-based mental health systems grounded in respect for human rights.** Deinstitutionalization is

central to this transformation: it seeks to move away from models of care that promote segregation and ensure that people can access the services and supports they need in their communities.

In the context of World Mental Health Day 2026, whose theme highlights the importance of lived experience, and following the launch of WHO's practical guide to the deinstitutionalization of psychiatric hospitals, **this report analyzes the progress and setbacks on the path toward deinstitutionalization in Peru.**

The study examines deinstitutionalization in Peru from a human rights perspective, identifying key progresses, challenges, and risks of reversal. It reviews developments in mental health legislation and public policy at national and international levels, analyzes the transition to a community-based model, and draws on the experiences of people who have been institutionalized to bring their voices and perspectives into the analysis.

Through these components, the report **aims to contribute to the debate on how to uphold the right to live in the community and strengthen a mental health reform** centered on autonomy, participation, and the full exercise of people's rights.

We present the findings of our research below.



Image: Victor Larco Herrera Hospital

2. METHODOLOGY

This study uses a **mixed-methods approach**, drawing on primary and secondary sources to bring together information from different perspectives.

2.1 Data collection

Data collection for this study included **in-depth, semi-structured interviews with people with lived experience of institutionalization.** These interviews capture both retrospective accounts and reflections shared in real time, providing a more detailed understanding of participants' experiences and perspectives (Gioia et al., 2013).

A total of ten people were interviewed: 50% identified as women, 30% as men, and 20% as non-binary. Seventy percent of the sample identified as heterosexual, 10% as homosexual, 10% as bisexual, and 10% as pansexual. In addition, 10% of participants identified as trans. Ages at the time of the interview ranged from 17 to 49 years. Regarding place of residence, 90% of the sample reported living in Peru: 40% in Lima, 20% in Cusco, 10% in Piura, and 10% in Callao. The remaining 10% reported living abroad.

Seventy percent of participants reported having been admitted to a public hospital, including Víctor Larco Herrera National Hospital, Hermilio Valdizán Hospital, Edgardo Rebagliati Martins Hospital, Cusco Regional Hospital, and the Honorio Delgado–Hideyo Noguchi National Institute of Mental Health. The remaining 30% reported admission to a private institution, including Caravedo Psychiatric Clinic, the "Amor de Cristo es la salvación" therapeutic community, and ABINT Terapias Integradas. Thirty percent reported more than one experience of institutionalization related to their mental health.

Age at the time of first institutionalization ranged from 13 to 48 years, and 80% of participants were institutionalized before the age of 35. As for the length of institutionalization, 10% of participants were hospitalized for less than one week, 60% for between one week and one month, 10% for between one and six months, and 20% for more than one year.

Finally, 75% of the institutions in which participants had been hospitalized were located in Metropolitan Lima, while 25% were located in other regions of the country, specifically Cusco and La Libertad.

The research team developed interview guides covering the following themes:

- Context prior to institutionalization
- Experience and living conditions within the institution
- Rights, autonomy, and decision-making during institutionalization
- Leaving the institution and the process of returning to the community
- Current life and participation in the community
- Access to community services and community-based supports
- Reflections and recommendations from lived experience

We used thematic analysis to examine the interviews. This method identifies, analyzes, and reports themes or patterns within a dataset through repeated reading of the material collected (Braun & Clarke, 2006; Fereday & Cochrane, 2006).

These themes help **capture and code information relevant to the research objective.** This method offers a valuable way to understand participants' experiences and perceptions, the meanings they attach to them, and how their social context may shape those meanings (Braun & Clarke, 2006).

We also conducted a **document review to compile, analyze, and interpret information from relevant secondary sources.**

The review identified recent studies, academic articles, laws, policies, and statistics relevant to the research. We consulted documents from Peruvian institutions, including the Ministry of Health, the Ombudsman's Office (Defensoría del Pueblo), and the Office of the Comptroller General of the Republic (Contraloría General de la República). We also reviewed reports, guidance, and studies from international bodies and organizations, including the United Nations (UN), the Inter-American Commission on Human Rights (IACHR), and United for Global Mental Health.

2.2 Ethical considerations

Given the sensitivity of the topics and the possibility that participants might recount rights violations or potentially traumatic experiences, **the research team developed ethical and safeguarding guidelines.** These informed the planning, conduct, and closure of the interviews, prioritizing participants' dignity, autonomy, well-being, and safety over data collection at every stage.

The guidelines established that interviewees would be recognized as experts in their own experiences and that their participation would be voluntary. Participants could choose the interview format, request breaks, decline questions, change the subject, or end the interview at any time without giving a reason. The team used clear, respectful language and active listening, avoiding questions or practices that could blame, pressure, or retraumatize participants. Interviewers were also trained in psychological first aid.

Before each interview, **the objective and scope of the study, the voluntary nature of participation, the measures for confidentiality and anonymization of information, and the intended use of the testimonies were clearly explained.** Time was provided to address any questions or concerns that might arise before the conversation began, and the corresponding consent was requested for participation and, where applicable, for note-taking and/or recording. Participants were informed that they could withdraw their participation or stop the interview at any time.

One participant in the study was a minor, for whom **additional ethics and safeguarding protocols** were adopted. Before any arrangements for the interview were made, written informed consent was obtained from one of the participant's parents, who received information about the study's objectives, scope, conditions of participation, and confidentiality measures. In addition, before the interview, the purpose of the participant's involvement, its voluntary nature, and the right to decline to answer certain questions, request a break, or end the interview at any time were explained directly to the participant in age-appropriate language. Participation was thus subject to both the informed consent of the legal guardian and to the assent of the person being interviewed.

In addition, **measures to support participants and the research team care measures were established.** If distress arose during an interview, priority was given to the possibility of pausing or ending the conversation, and there was no insistence on

exploring further the topics that had triggered that reaction. Where appropriate, information on available support resources was provided. The research team also had spaces for coordination, listening, and emotional support during the fieldwork, recognizing the possible emotional impact of the data collection process as well.

The information collected was treated confidentially, and measures were taken to avoid including any data that could identify participants. Their accounts have been anonymized in this report.

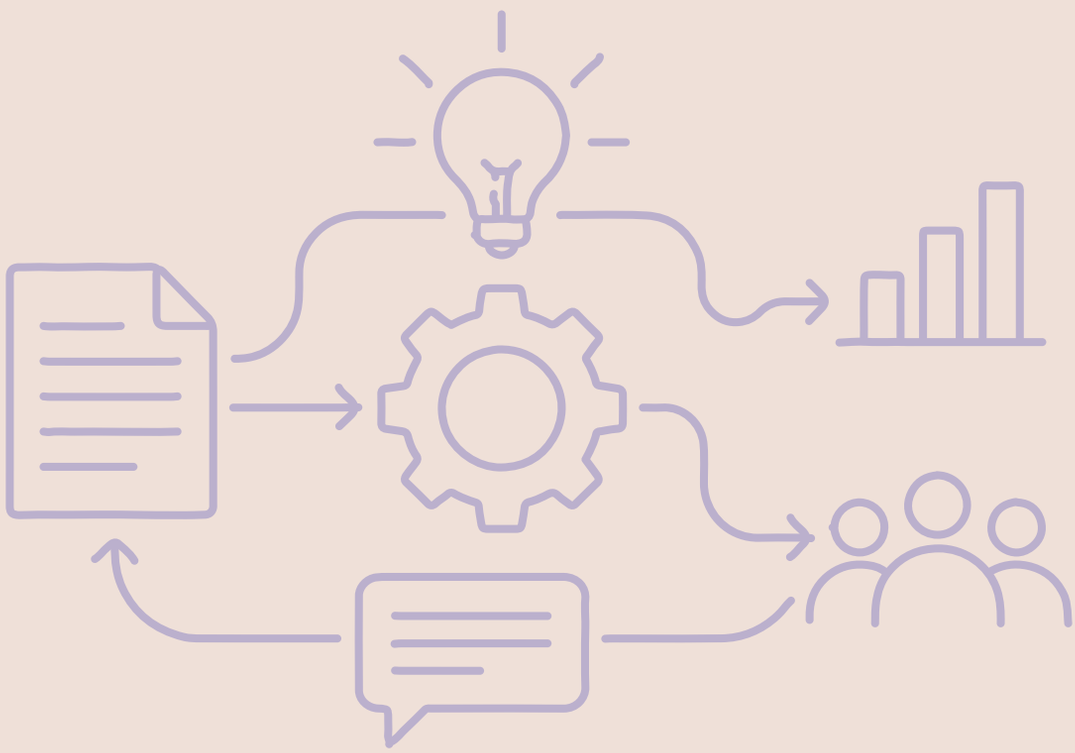




Image: Ojo público

3 What is deinstitutionalization and why does it matter?

Deinstitutionalization **transforms how society responds to mental health and support needs.** It replaces a model based on psychiatric hospitals and other long-stay institutions with a network of person-centered community services and supports. Its purpose is to enable people to live and participate in the community, access quality care, and retain control over decisions affecting their lives. This requires changes to services, resources, and power relations.

3.1. Deinstitutionalization and the community-based model of care

For the purposes of this report, we understand mental health institutions as facilities intended to provide mental health care under a model of medium- or long-term hospitalization or residence. As such, the term includes psychiatric hospitals, asylums, and other residential or institutional facilities that may involve separating people from their communities and limiting their autonomy and participation in community life.

Closing mental health institutions does not, by itself, deinstitutionalize mental health services. Reductions in long-stay facilities or hospital beds must be accompanied by effective alternatives for care and support in the community. The Pan American Health Organization (PAHO) proposes replacing the functions of psychiatric hospitals with community services, supported housing, and care for acute crises in general hospitals.

Deinstitutionalization therefore requires reorganizing public services so that discharge does not mean losing access to care and support (PAHO, 2020).

However, moving care out of hospitals does not, in itself, guarantee that institutional practices have been overcome. **When reforms focus on closing or downsizing facilities without transforming the systems of care and the power relationships within them, there is a risk that those same practices will be reproduced in other settings**, even in smaller or community-based services. The Committee on the Rights of Persons with Disabilities (CRPD Committee) identifies practices such as segregation, the imposition of routines, and the absence of personal choice. Moving people to smaller facilities, renaming a service, or renovating its infrastructure may therefore preserve that same logic. For this reason, the transformation must go further and ensure that people regain control over their own lives and can decide how, where, and with whom to live (CRPD Committee, 2022, paras. 14–20).

This distinction offers concrete questions for assessing reforms. Can people choose who supports them? Can they maintain their relationships and activities? Is housing available without having to accept treatment they may not agree with? Can they get help during a crisis? The answers help establish whether the transition expands people's opportunities to live and develop or simply changes where care is provided.

WHO (2021a) proposes a **combination of community centers, crisis care, outreach teams, peer support, hospital services, and support for community living.** Coordinating these services makes it possible to respond to different needs and maintain continuity of care. The community-based model thus integrates specialized care within a person-centered, rights-based system.

Geographic proximity makes access easier, but does not guarantee autonomy. Assessing whether a mental health center is community-based also requires looking at its relationships with people, the choices it offers, and its links with mainstream local services. The network must be able to support people with different life experiences and needs, including those who require intensive or long-term support.

Housing is part of this response. WHO includes supported living services in its guidance on transforming mental health systems. For policymakers, this means ensuring that people have somewhere to live and support tailored to their needs, rather than addressing every need through placement in a segregated residence (WHO, 2021b).



Image: MINSA

Table 1. Institutional model and rights-based community model

Dimension	Segregated institutional model	Rights-based community model
Organization	Life and care are concentrated in a single facility.	Health services and supports are coordinated across the territory.
Decision making	Decisions by the health staff in charge and collective routines predominate.	Will and preferences are respected, with support for decision-making.
Daily life	Schedules, activities, and relationships depend on institutional rules.	The projetcs and activities chosen by the person are supported.
Crisis response	Separation from the person's enviroment and control predominate.	Rights-respecting alternatives for support and care are developed.
Housing and supports	Care often depends on accommodation in the institution (hospitalization).	Housing options and individualized supports are expanded.
Participation	People are mainly recipients of care.	People take part in the design, delivery, and evaluation of services.
Evaluation	Beds, discharges, and compliance with routines are prioritized.	Acces, continuity, autonomy, and inclusion are examined.

Source: Prepared by the authors, based on WHO (2021a) and the CRPD Committee (2017, 2022).
Note: The table compares approaches to organizing care; it does not describe all existing hospital or community services in the same way.

3.1.1. Lessons from international experience

International experience shows how deinstitutionalization can transform mental health systems. These examples must, however, be understood in context: an outstanding local initiative does not necessarily represent an entire country, and fewer hospital admissions alone do not demonstrate comprehensive improvements in rights. Both the alternatives developed and the conditions that sustain their outcomes need to be examined.

3.1.1.1. Italy and the Trieste experience

Trieste is a leading example of replacing a psychiatric hospital with a network of local services, and WHO includes it among its examples of comprehensive mental health service networks. Its significance lies in coordinated responses and continuous support, rather than care organized around a long-stay facility (WHO, 2021c).

One study followed 39 people experiencing acute, severe mental health crises over four years. They received care at a community center open 24 hours a day, seven days a week. The authors reported generally favorable outcomes from the initial crisis onward, with few relapses and positive longer-term trends. However, this was an observational study with a small sample, published in 1995. It demonstrates the feasibility of this approach, but cannot guarantee the same outcomes in every health system (Mezzina & Vidoni, 1995).

For Peru, **this example raises questions about access to help outside normal appointment hours, coordination between teams, and continuity of support.** Opening a center without addressing what happens during a nighttime crisis or after discharge leaves a critical gap in the network.

3.1.1.2. Brazil and the expansion of alternatives to hospital care

Brazil offers a Latin American experience of **reorganizing public care through Psychosocial Care Centers** (Centros de Atenção Psicossocial), known as CAPS. A study of hospitalizations in the *Sistema Único de Saúde* (Brazil's Unified Health System) between 2000 and 2014 found associations between the reduction in beds, the expansion of CAPS, and the reduction of some hospitalization rates. Nonetheless, the analysis itself cautions that the limited development of continuous care services made it difficult to reduce hospitalizations (Rocha et al., 2021).



Image: Igor Santos/Secom PMS

These findings **support the importance of developing alternatives alongside hospital transformation.** However, the associations are observational: they do not establish that every area has an adequate service network or that coercive practices have been eliminated. To draw lessons for other countries, coverage, responsiveness, and quality of care must be assessed alongside service-use indicators.

3.1.1.3. The United Kingdom and life after discharge

The Team for the Assessment of Psychiatric Services (TAPS) project followed people discharged from two London hospitals. Of an initial cohort of 670 people, data were available for 523 at the five-year follow-up. Although there were no observed changes in clinical status or social behavior problems, everyday living skills, friendships, and personal freedom improved. Most people preferred to remain in their homes. The authors **linked these quality-of-life improvements to a planned, adequately resourced transition** (Leff & Trieman, 2000).

3.2 Global human rights standards

The **CRPD recognizes the equality, autonomy, and participation of persons with disabilities. Articles 5, 12, 19, and 25 connect non-discrimination, legal capacity, community living, and access to health care**. In mental health, this framework helps identify the barriers faced by people with psychosocial disabilities and shifts the focus from guardianship to the exercise of rights (United Nations, 2006).

Deinstitutionalization therefore has legal and political dimensions. **Access to care must allow people to make decisions and participate in society.** A service cannot be considered successful solely because it achieves clinical stabilization: its effects on people's freedom, privacy, and plans for their lives must also be considered.

3.2.1. The right to live in the community

Article 19 of the CRPD recognizes the right to choose one's place of residence and with whom to live, without being obliged to live in a particular living arrangement. It also provides for access to community support services that prevent isolation and segregation. This right applies to all persons, including those who need extensive support, and does not depend on their being able to carry out all their activities without assistance (United Nations, 2006, art. 19).

General Comment No. 5 explains that **living independently entails choice and control over one's own life.** A lack of alternatives, inaccessible housing, or support being available only within an institution can prevent that choice. It also warns that family members or others may restrict decisions even in the absence of a formal legal prohibition (CRPD Committee, 2017, paras. 16 and 24–28).

To apply this right, **it is useful to distinguish between the presence of family members and the existence of a sufficient support network.** Returning home may be a desired option, but it does not automatically address care needs, economic problems, or protection from violence. Public policy must offer alternatives for those who have no family available, do not wish to live with their family, or require other forms of support.

> ***As soon as I turned 18, I left home because I needed to escape an environment that was very toxic, violent, and dysfunctional. From then on, I gradually built my independence, studying and working, because I didn't have a support network in my family.***
>
> - Testimony of Participant 06 about their family situation.

3.2.2. Autonomy and legal capacity

Legal capacity encompasses recognition as a holder of rights and the ability to exercise them. The CRPD Committee distinguishes this recognition from assessments of decision-making skills. Its General Comment No. 1 holds that **support must respect the person's will and preferences and avoid substituting for them.** It also requires safeguards against abuse and undue influence (CRPD Committee, 2014, paras. 12–22).

In practice, support may involve explaining information differently, facilitating communication, or helping someone compare options. **The guiding principle is that assistance should strengthen the person's ability to act.** The level of support may change, but needing it should never become blanket permission for others to control the person's life.

3.2.3. Informed consent and decisions about care

Informed consent requires a freely made decision based on information the person can understand. Article 25 of the CRPD recognizes the provision of health care on the basis of free and informed consent. WHO and OHCHR's joint guidance calls for legal reforms to eliminate coercion and strengthen community services that respect dignity (United Nations, 2006, art. 25; WHO & OHCHR, 2023).

A signature alone cannot establish whether this process was adequate. Did the person understand the proposed care, have an opportunity to ask questions, and have the conditions needed to decide freely? Assessing services therefore requires examining how they explain alternatives, risks, and treatment changes, and what support they provide when communication is difficult.

The CRPD Committee maintains that care should not be imposed through a decision made by a substitute decision-maker on the person's behalf. This position is part of its interpretation of the right to legal capacity. Its implementation requires support alternatives and advance planning, as well as procedures that respond to complex situations while respecting the person's will and preferences (CRPD Committee, 2014, paras. 29 and 41–42; WHO, 2019).

> ***It was my sister who had me admitted (...). They admitted me without my consent, and I'm going to say that, because afterward I had to work through it with my psychologist (...). My sister and the psychiatrist were arguing, and then the head nurse came in. She was a friend of my sister's. The psychiatrist didn't want to admit me; she wanted to send me home with medication. So my sister called her friend, who's involved in the nurses' union or something like that. And between them, my sister and the nurse practically forced the psychiatrist to admit me.***
>
> - Testimony of Participant 02 about their experience of institutionalization.

3.2.4. Non-discrimination and accessibility

Non-discrimination encompasses **equality before the law, as well as reasonable accommodation to exercise rights.** Such accommodation makes it possible to respond to specific barriers without imposing a single way of communicating, understanding, or participating (United Nations, 2006, arts. 2 and 5). In care settings, this may take the form of accessible information, communication adaptations, or changes to the environment according to each person's needs.

For services, this means identifying barriers that often go unnoticed: loud noise, information available only in writing, a lack of interpreters, or administrative procedures that require internet access. Services designed without considering different disabilities, ways of communicating, languages, and cultural contexts can restrict access and participation. Community services need an intercultural approach, reflected in how they operate from day to day.

3.3 Global progress and challenges in deinstitutionalization

Recent international frameworks reflect a **shared commitment to community services, supported decision-making, and participation.** WHO published guidance on community mental health services in 2021; the CRPD Committee adopted guidelines on deinstitutionalization in 2022; WHO and OHCHR issued joint guidance on mental health, human rights, and legislation in 2023; and WHO launched its first practical guide to deinstitutionalization in 2026 (WHO, 2021a; CRPD Committee, 2022; WHO & OHCHR, 2023; WHO, 2026c).

WHO guidance on policies and action plans addresses the social and structural determinants of mental health, collaboration across sectors, and the participation of people with lived experience. It connects service reform with housing, education, employment, and living conditions (WHO, 2025b).

These frameworks set a shared international direction for mental health service reform.

They establish legal and technical guidance, but do not demonstrate unanimous agreement among governments, professionals, and organizations, or consistent implementation. The challenge is to **translate them into budget decisions, services, and accountability mechanisms suited to different contexts around the world.**

3.3.1. QualityRights: toward rights-based mental health services

QualityRights is a WHO initiative aimed at **transforming mental health and related services to ensure respect for human rights, promote recovery, and foster person-centered care.** It is an initiative developed in line with the CRPD that provides tools for assessing quality and respect for rights in services, as well as training and guidance materials to drive changes in practices and in the organization of services (WHO, 2019).

Its approach addresses **dimensions closely linked to deinstitutionalization**, including respect for legal capacity and supported decision-making, informed consent, protection from violence and abuse, the reduction and elimination of coercive practices, advance planning, and peer support. It also incorporates standards related to the right to live independently and be included in the community, in line with Article 19 of the CRPD (WHO, 2019).

QualityRights contributes to **international efforts to move mental health systems from institutional models toward community-based services and supports.** It helps identify and change practices that perpetuate institutionalization and promotes relationships of care grounded in dignity, autonomy, choice, and community inclusion (WHO, 2019).

However, its impact depends on its principles being translated into effective changes in policies, protocols, practices, and accountability mechanisms. Training should therefore be understood as a starting point rather than an end in itself: it is necessary to assess whether people can effectively participate in decisions about their care, exercise their legal capacity, access safe complaint mechanisms, and be protected from coercion, abuse, and segregation.

3.3.2. Lived experience as essential knowledge

In 2023, WHO published guidance on the **meaningful engagement of people with lived experience in policies, programs, and services.** It aims to turn intentions into practical arrangements for collaboration and co-creation, recognizing that using services, seeking support, and facing barriers generate knowledge essential to transforming mental health systems (WHO, 2023).

The 2026 World Mental Health Day campaign similarly emphasizes that lived experience

must inform policy and services at every stage, from design to implementation and evaluation. It also cautions that no single person can represent the full diversity of experiences. Meaningful participation goes beyond sharing an account: it means being able to influence decisions (WHO, 2026b).

Recognizing lived experience as expertise is essential to transforming mental health systems. People who have experienced mental health problems, used services, or faced barriers bring knowledge that complements professional, academic, and technical expertise. WHO (2025b) highlights how integrating this expertise into policies, services, and communities helps build more inclusive, recovery-oriented systems.

> ***Patients' experiences should be taken into account too, rather than only looking at what professionals say. I think there are other kinds of knowledge, patients' knowledge, other epistemologies, that can help improve mental health, but sometimes the only approach considered is Westernized psychology.***
>
> – Testimony of Participant 10.

Lived experience must therefore be recognized as expertise on an equal footing with other forms of knowledge, with real opportunities to influence decisions and transform mental health systems. This must include people who are institutionalized, those with greater support needs, and communities that have traditionally been underrepresented. Sustaining their participation also requires practical resources and conditions, including time, accessibility, and recognition of their work.

3.3.3. The WHO practical guide to deinstitutionalization

In October 2026, WHO published a **practical guide to the deinstitutionalization of psychiatric hospitals**, entitled "Supporting the transition to community-based mental health and social care". Its development drew on contributions from social organizations, advocates, and people with lived experience, including De-Mentes, representing Peru (WHO, 2026c).

Aimed at hospital managers and decision-makers, the guide proposes actions to advance toward deinstitutionalization in three stages–plan, prepare, and provide support–and in three areas: reducing admissions and prolonged stays, transforming care practices within hospitals, and strengthening supported discharge, continuity of care, and community participation (WHO, 2026c). In this regard, the document states that **deinstitutionalization requires a comprehensive transformation that links policies, legislation, and financing with**

community mental health services and supports for community living. It also highlights the importance of coordination among authorities, services, families, and people with lived experience in sustaining this process (WHO, 2026c).

These guidelines reinforce that deinstitutionalization requires more than closing or downsizing psychiatric hospitals. It requires **real alternatives for living in the community, with adequate support, autonomy, and continuity of care.** The challenge is to translate global guidance into sustainable decisions, resources, and services at regional, national, and local levels, with meaningful participation by people with lived experience and mechanisms to assess outcomes from a human rights perspective.



Five key ideas about deinstitutionalization



1. The transition requires real alternatives in the community

Deinstitutionalization means developing services and community-based supports that enable people to leave segregated institutions and prevent others from being institutionalized. Closing hospitals alone is not enough. Discharge must come with access to care, housing, and everyday support.



2. Living in the community is a right

Community living encompasses choice and control over how, where, and with whom to live. Needing support does not eliminate this right. Options must also be available for those who require intensive support or who do not have family members able to provide it.



3.Care must respect autonomy

Rights-based care respects the person's will and preferences. Information people can understand and support to make decisions are part of care. Consent must be assessed as a process, as well as a written record.



4. Labeling a facility as "community-based" does not guarantee change

A small facility or one close to home may retain institutional practices. Evaluation should look at day-to-day autonomy, the relationship with care teams, and opportunities for participation, together with the coverage and continuity of services.



5. Lived experience must influence the reform

People who have used services bring valuable knowledge about their barriers and potential. Their participation must influence design, implementation, and evaluation. Listening to their accounts matters; using that knowledge to change decisions is what advances meaningful participation.

Source: Prepared by the authors, based on United Nations (2006), CRPD Committee (2014, 2017, 2022), PAHO (2020), and WHO (2019, 2021a, 2023, 2026b).



Image: Andina

4 The path toward deinstitutionalization in Peru

Peru's mental health reform has brought changes to regulation, public funding, and service organization, centered on the transition to community-based care. Yet establishing this model and advancing deinstitutionalization remain challenging, with consequences for people's ability to live in the community with autonomy and adequate support.

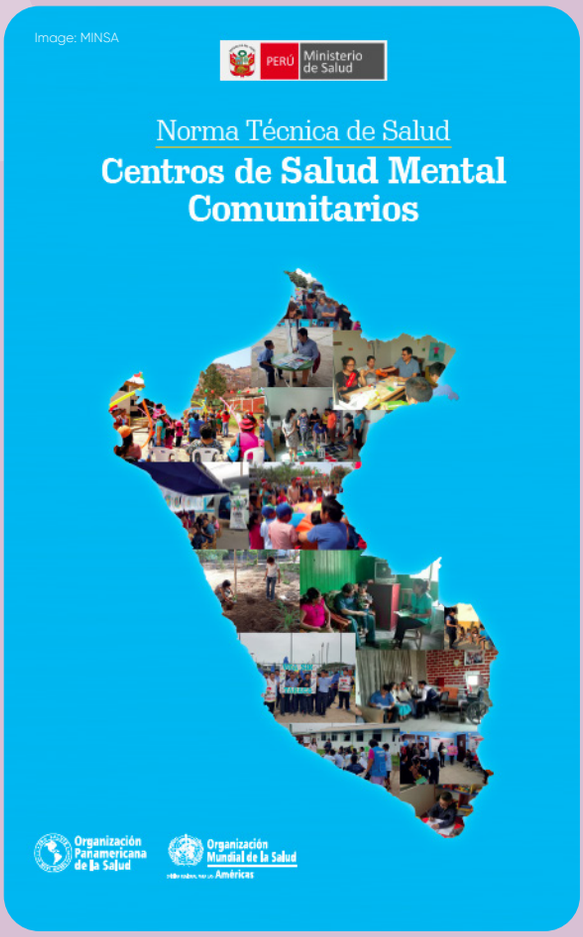
4.1 From the institutional model to the community-based model

Launched in 2012, **Peru's mental health reform proposed a transition from a model centered on psychiatric hospitals to community-based care.** The aim is to uphold people's rights by organizing care around the person and their mental health needs. Depending on their needs, people can access primary care facilities, community mental health centers (CSMCs), mental health and addiction inpatient units (UHSMAs) in general hospitals, and supported homes (hogares protegidos, HPs). Within this framework, institutionalization in specialized psychiatric hospitals or private facilities should be exceptional, reserved for specific circumstances and subject to human rights safeguards.

The starting point for the reform was the 2012 amendment of Article 11 of the General Health Law through Law No. 29889, which established community-based care as the foundation of mental health service delivery. Its implementing regulations, approved through Supreme Decree No. 033-2015-SA, enabled the creation of Budget Program (PP) 131, "Mental Health Control and Prevention," which has since brought together funding specifically allocated to

the reform (Ministry of Health of Peru [MINSA], General Office of Planning, Budget, and Modernization [OGPPM], 2025). The first CSMCs and a framework of measurable results were introduced that same year, marking the first steps in implementing the model (Castillo-Martell & Cutipé-Cárdenas, 2019).

Two measures adopted in 2018 further supported the community-based model. The first National Plan for Strengthening Community Mental Health Services (2018–2021, Ministerial Resolution No. 356-2018/MINSA) set objectives, activities, a budget, and responsibilities for implementation. Legislative Decree No. 1384 also amended the Civil Code to recognize the full legal capacity of persons with disabilities. It abolished legal incapacitation and replaced it with a system of support and safeguards, in line with Article 12 of the CRPD. **This reform matters for deinstitutionalization because it removes one of the legal grounds historically used to make decisions for people rather than with them.**



Subsequently, **in 2019, Law No. 30947, the Mental Health Law, was enacted, and its implementing regulation was issued in 2020 through Supreme Decree No. 007-2020-SA.** In 2023, the National Plan for Strengthening Community Mental Health Services 2024-2028 was approved; in terms of design, it is a direct continuation of the 2018-2021 plan. It maintains the objective of expanding the network of CSMCs, UHSMAs, and HPs, and explicitly incorporates recognition of the role of the education and labor sectors in addressing mental health (De-Mentes, 2025).

Together, these legal and technical instruments propose a substantial departure from the previous hospital-centered model. **Instead of concentrating care in long-stay psychiatric hospitals, the community-based model organizes it through a coordinated network of outpatient services** close to people's homes, with family and community participation. The Health Technical Standard for Community Mental Health Centers (NTS No. 138-MINSA/2017/DGIESP, approved by Ministerial Resolution No. 574-2017/MINSA) defines this range of services. It organizes each CSMC into four functional units: Children and Adolescents, Adults and Older Adults, Addictions, and Community Participation.

Unlike the hospital model, which prioritizes recovery from acute crises through hospitalization, **the community-based model explicitly incorporates promotion, prevention, recovery, and psychosocial rehabilitation as equally necessary functions, with the stated aim of preventing people from losing their family, work, and social ties during treatment.** In 2023, MINSA complemented this legal framework with the Technical Guide on Continuity of Care in Community Mental Health (Ministerial Resolution No. 663-2023/MINSA), which seeks to

ensure that people with severe mental health problems do not become disconnected from services when moving from one level of care to another. This is a risk inherent to a system with multiple points of entry (primary care, CSMC, UHSMA, HP) which, without shared follow-up mechanisms, can fragment care rather than make it more continuous.

These legal and technical instruments lay the foundations for a transition that prioritizes deinstitutionalization. Yet **this promising legal and policy framework has not been fully translated into practice.** Major gaps remain between commitments and actual conditions of care across the country, both in the availability and coordination of services, as well as in guaranteeing autonomy and the right to live in the community.

4.2 Progress and challenges of the mental health reform

Over the past decade, Peru's mental health reform has made tangible progress in regulation, public funding, and the availability and coverage of services.

Both service availability and the number of care visits have increased. CSMCs are a cornerstone of Peru's community-based model, and the network grew from 22 centers in 2015 to 306 when this report was finalized (Mental Health Directorate of the Ministry of Health of Peru [DSAME], 2026a). Services have also reached more people: 1,314,807 received care in 2024, with coverage rising to 33.7%, compared with 28.3% in 2019 (MINSA-OGPPM, 2025).

Figures from the Ministry of Economy and Finance (MEF)'s budget portal (2026) **show sustained growth in mental health funding, although the pace has slowed in recent years.** PAHO recognizes Peru as a regional example of using results-based financing to advance mental health reform (PAHO, 2023).

Official figures show that the revised institutional budget (PIM) for PP 131, "Mental Health Control and Prevention," rose from Peruvian soles (PEN) 87 million in 2015 to PEN 761 million in 2025 (Chart 1). **Its share of public health spending increased from 0.6% to 2.3% over the same period.** However, this **remains well below the 5% recommended for low- and middle-income countries by the Lancet Commission on Global Mental Health and Sustainable Development** (2018).

These advances coexist with structural gaps that limit the reach of community-based care and compromise its quality. The most significant are insufficient services, inadequate infrastructure and basic utilities, and staff shortages.

The opening of new CSMCs has slowed markedly since 2023, putting Peru further off track to reach its target of 506 centers by 2026. The Ombudsman's Office's review of supported homes (2025), which are essential to deinstitutionalization for people without family support, also **confirms that this remains one of the least developed parts of the model.** The 2018–2021 Plan projected at least 170 homes by 2021, but only 94 existed when this report was finalized (DSAME, 2026a).

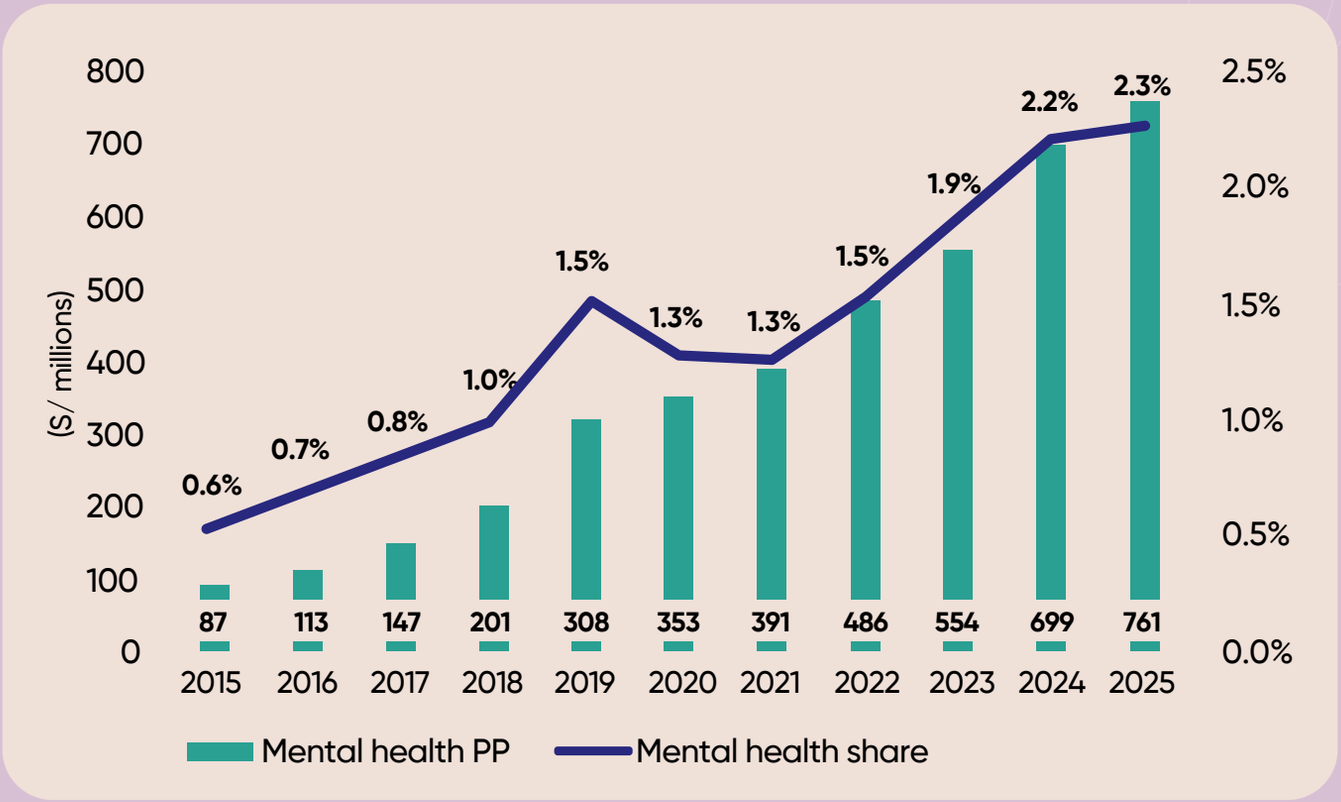


Chart 1. Revised institutional budget for Budget Program 131, 2015–2025 (PEN millions).
Source: MEF, budget consultation portal (Consulta Amigable), 2026; prepared by the authors.
Note: Figures cover the revised budget under the Health Function budget classification and PP 131's share of that budget across all levels of government. They exclude EsSalud, the Armed Forces, and the National Police.

The shortage of mental health and addiction inpatient units in general hospitals is another gap. Their expansion has been slower than that of **CSMCs.** In 2018, 74.5% of general hospitals classified as level II-2 or above lacked a UHSMA (Ombudsman's Office, 2018). By 2023, this had fallen to 65.3% (PAHO, 2023), **an improvement that still leaves two in three hospitals that should provide such a unit without one.**

MINSA (2024) also identifies insufficient service provision, both in the number of general hospitals with UHSMAs and in the availability and accessibility of medical support services for care and rehabilitation. It notes that mobile services for remote or dispersed populations and for people experiencing both mental health problems and homelessness remain at an early stage of development.

Infrastructure and basic utilities are also inadequate in several mental health facilities, affecting care quality. Reports from the Office of the Comptroller General document CSMCs operating in rented premises, facing a constant risk of eviction, and lacking basic utilities (2025a). They also document non-functioning equipment and deteriorating, unsanitary conditions at Víctor Larco Herrera Hospital, the country's main psychiatric referral center (2025b).

With regard to human resources, **MINSA itself (2024) acknowledges an insufficient supply of specialized staff in mental health services.** It indicates that 678 psychiatrists work in MINSA and regional government facilities, mainly in specialized hospitals and in Lima, which means fewer professionals in other regions. According to WHO (2022a), in 2020 Peru had 3.46 psychiatrists per 100,000 inhabitants, a figure below WHO's reference of 5 psychiatrists per 100,000 inhabitants. A similar situation is observed for psychologists,

with an average rate of 24.8 per 100,000 inhabitants as of 2023. In addition, MINSA (2024) estimated a gap of approximately 350 psychologists to reach the minimum staffing required by CSMCs. Based on 2023 data, it also identified shortfalls of 1,666 occupational therapy professionals, 80 social workers, and 487 nursing professionals specialized in mental health needed to form the multidisciplinary teams required in these centers.

These infrastructure and staffing gaps directly affect how community-based care works in practice. A CSMC without enough staff or adequate premises cannot fully carry out the community participation, promotion, and prevention functions that distinguish it from the hospital model. **Its limited resources tend to be concentrated on individual clinical care, reproducing the approach the reform seeks to change.**

Community participation and the involvement of community health workers and people with lived experience are essential to the model (PAHO, 2020; WHO, 2021d). In Peru, however, **these components are noticeably less developed than others.** Available evidence mainly concerns individual initiatives, such as work with community health workers led by the Honorio Delgado–Hideyo Noguchi National Institute of Mental Health (INSM) in the Lima districts of San Martín de Porres, Independencia, and Los Olivos (INSM, 2026). There is no evidence of a systematic, nationally evaluated approach.

We could not identify an official, publicly available figure for the number of community health workers connected to the national CSMC network. Nor did we find indicators tracking the participation of people with lived experience in service design or evaluation. **This gap matters because community participation and lived experience are foundations of the model and help distinguish it from traditional hospital-based care.**

Additionally, **funding remains misaligned with the community-based approach that the reform itself promotes.** Between 2019 and 2025, according to data from the MEF's Consulta Amigable portal (2026), more than 90% of public spending went to individual clinical care, while risk prevention in vulnerable populations accounted for barely 2% of individual health



Image: Office of the Comptroller General of the Republic

spending and psychosocial rehabilitation activities did not exceed 4% (Chart 2). This is despite the fact that the available evidence supports the cost-effectiveness of the community-based model compared with the hospital model. One study found that the 29 CSMCs created between 2015 and 2017 handled a volume of consultations similar to that of the country's three main psychiatric hospitals (244,000 versus 246,000 consultations, and between 46,000 and 48,000 people served under each model), but using only 11% of the funding and 43% of the psychiatrists employed by the hospitals (Castillo-Martell & Cutipé-Cárdenas, 2019). **These findings reflect the need to continue increasing the public resources allocated to the community-based model.**

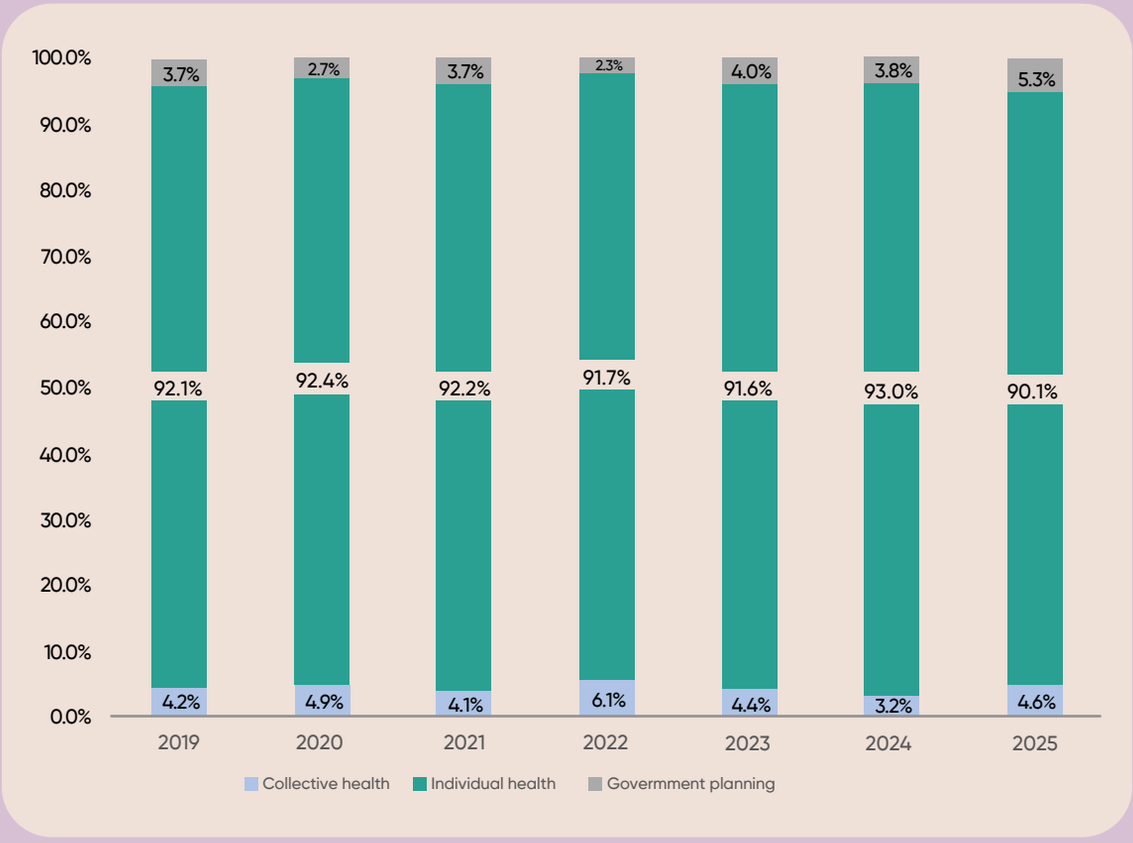


Chart 2. Distribution of the public mental health budget by type of expenditure, 2019-2025. Source: MEF Consulta Amigable, 2026.

National plans are also disconnected from operational funding. An earlier De-Mentes study found that although the 2024–2028 National Plan recognizes the roles of education and employment, it has no identifiable budget lines through which this cross-sector work can be monitored (De-Mentes, 2025).

Information gaps also limit scrutiny of spending and progress under the current plan. MEF's Consulta Amigable portal does not provide enough detail for a thorough analysis of expenditure, and very few CSMCs have their own patient follow-up systems (De-Mentes, 2025; MINSA-OGPPM, 2025). Two years after the second National Plan for Strengthening Community Mental Health Services (2024–2028) took effect, **no public report measures progress against its targets.** DSAME regularly publishes activity bulletins, but these do not report performance against the plan's indicators. In response to a request under the Transparency and Access to Public Information Law, MINSA shared with the research team a matrix tracking progress through 2025 (DSAME, 2026b), which shows that a series of targets were met. According to the matrix, unmet targets, including establishing and

operating CSMCs and expanding UHSMA services, reflect the lack of funding allocated to these activities under the 2025 Budget Law. However, making access to this information dependent on a citizen request is inconsistent with proactive transparency. These gaps in publicly available information limit the ability of civil society, academia, and oversight bodies to assess whether the reform is advancing at the promised pace.

Limited publicly available statistics further hinder scrutiny of how resources are used. The Mental Health Observatory reports only two indicators: the percentage of people receiving care for mental health problems and the number of care visits per person. Although data are broken down by region, age, sex, and facility type, they do not allow analysis of differences in access or outcomes among groups facing vulnerability, such as persons with disabilities, Indigenous communities, and migrants. This information gap is even wider in other parts of the health system, including EsSalud (Peru's social security system), the Armed Forces, the National Police, and private services.

Another challenge is the gap between legislation and implementation. **Peru has extensive mental health legislation, but publicly available evidence does not demonstrate compliance with several core requirements.** For example, the implementing regulations of Law No. 30947 (Supreme Decree No. 007-2020-SA) established the National Mental Health Council to monitor and oversee policy, the intersectoral plan, and the five-year community services plan, and to issue technical reports. Although its creation was announced in October 2020 (Andina, 2020), more than six years later we could find no public information confirming its regular operation, such as internal rules, meeting minutes, reports, or the Intersectoral Mental Health Plan.

A second example is community participation. Health Technical Standard No. 138-MINSA/2017/DGIESP establishes it as a functional unit of every CSMC. However, no public information is available to verify its systematic implementation. Both cases show that regulatory progress does not, in itself, guarantee effective application in services.
These gaps between regulation and practice directly affect access to services, their use, and the quality of care. **Interviewees also described difficulties navigating the mental health system**, particularly the barriers to accessing services and continuing treatment.

> ***I've been to several community mental health centers, but the problem is that the staff change all the time. Just when you're finally building a relationship with a psychologist or psychiatrist, suddenly they're gone and you have to start over with someone else. It's frustrating, because you get tired of telling your story again to so many doctors, and especially of having to open yourself up to building that trust again.***
>
> –Testimony of Participant 06

> *I went in with the psychiatrist's prescription and came out crying because the nurse at the pharmacy, the pharmacist, told me a stamp was missing, and the blue ink in the name wasn't the same blue as the part at the bottom. (...) I'm not asking for medication to mess around with. I'm asking for medication so I can keep living.*
>
> –Testimony of Participant 07

> *I've been to a community mental health center and, I mean, I think the idea of a community-based approach is interesting. But the center referred me to the public general hospital, where there's a psychiatrist, because the community mental health center doesn't have any psychiatrists. I think there just aren't enough professionals providing care.*
>
> –Testimony of Participant 10

Fragmentation is another major challenge for Peru's mental health reform, as separate financing and service delivery arrangements across health subsystems make it difficult to extend community-based care throughout the system. Within the public subsystem under MINSA, Comprehensive Health Insurance (SIS) provides financing, while services are delivered by facilities managed by the Integrated Health Network Directorates (DIRIS) in Metropolitan Lima and the Regional Health Directorates or Management Offices (DIRESA/GERESA) elsewhere in the country. Regional governments execute nearly two-thirds of the PP 131 budget (MINSA-OGPPM, 2025).

Other subsystems include EsSalud, which operates under the Ministry of Labor and Employment Promotion and finances and delivers care to its insured population; the Armed Forces and National Police health services, under the Ministries of Defense and the Interior, respectively; and the private sector. Although MINSA has statutory stewardship over all these subsystems (Law No. 26842, Art. 4-A), its capacity to guide and oversee them is limited. For example, EsSalud's implementation gap for supported homes stood at 100% in 2018 (Defensoría del Pueblo, 2018). Progress towards community-based care therefore

depends on decisions made across multiple institutions and on fragmented information. **The absence of data from EsSalud, the Armed Forces, the National Police, and the private sector also prevents a system-wide assessment of the model's reach.**

Effective coordination and oversight are urgently needed to ensure access to community-based services and supports across all subsystems, regardless of insurance coverage or provider. Without them, fragmentation risks deepening inequalities in access to care and in the exercise of the right to live in the community.

Finally, although international evidence increasingly recognizes the social determinants of mental health, the effects of climate change, and their unequal impact on vulnerable populations (WHO, 2022b; WHO, 2022c), these issues still have no specific budgetary or regulatory provisions within Budget Program 131.

The evidence reviewed here shows significant progress in legislation and funding since 2015. Yet **implementation across the country–in service availability, infrastructure, staffing, spending priorities, and information systems–remains far below the policy's own ambitions.** Upholding the right to live in the community requires protecting the pace of expansion of services such as CSMCs and supported homes, redirecting spending toward promotion, prevention, and recovery, and strengthening mechanisms through which the public and oversight bodies can scrutinize facilities and resource use.



Image: Andina



Image: Enrique Encinas Library at the Víctor Larco Herrera Hospital

5 Voices of people with lived experience of institutionalization

The accounts presented in this chapter cover different care settings, including public institutions run by MINSA or EsSalud, as well as private facilities.

The **findings should therefore be read with the understanding that rights violations are not confined to a particular administration or type of facility.** In a system as fragmented as Peru's, they highlight the need to strengthen community-based care across every subsystem. Care and support must respect human rights, autonomy, and community living, regardless of the provider or insurance scheme.

Drawing on these accounts, the following sections examine the main rights violations identified, the dynamics that perpetuate them, and the changes called for by people who have experienced institutionalization.

5.1 Decision or imposition? Institutionalization and informed consent

Institutionalization raises questions about respect for people's will and decisions. Do people receive enough information and have an opportunity to give consent before admission? The accounts gathered for this study help examine how admission decisions were made and whether people had a meaningful say in them.

Informed consent requires that the person receives clear explanations and be able to decide freely. Article 25 of the CRPD (2006) recognizes this principle in health care. In Peru, Law No. 30947 establishes that information must be accurate, sufficient, and understandable, and that acceptance must be given without undue persuasion (Congress of the Republic, 2019, art. 9.7).

In the experiences of Participants 01 and 03, their families made the decision to take them to a facility without their agreement. Participant 01 recounts that he was taken while he was asleep. He was unable to have a say in the decision, was not consulted, and did not sign any document:

> ***Basically, they kidnapped me. They came in the early hours while I was sleeping and just took me. That's how they take you. It's not like they knock on your door at two in the afternoon and say, 'Hey, it's time to go to the center.' The family gives people medication (...) clonazepam or diazepine, or something to make them sleep, and once they're asleep they take them away in the early hours. They took me in my underwear. (...) Obviously, I had no say in the decision. (...) I didn't sign anything; nobody asked me anything. I could have filed a complaint, but I don't want to hurt my parents, because I'd have to report them. So, legally speaking, you could call it kidnapping.***
>
> – Testimony of Participant 01

Participant 03, by contrast, recalls resisting being taken away. His mother and other relatives forced him to attend a psychiatric consultation, where the psychiatrist recommended admission to a hospital that same day. A professional recommendation followed the family's decision, and his refusal did not stop the admission:

> ***I was in a crisis, and my mom was the only person I would let see me. In her desperation, she decided to take me by force. A cousin pulled me out of my room–I was trying to stay there with what little strength I had–and put me in his car with my uncle and my mom. First, they took me to a psychiatrist at a clinic opposite the regional hospital (...). Then the psychiatrist told them, 'Better take him to the regional hospital and see if you can get him admitted today'.***
>
> – Testimony of Participant 03

Family intervention also influenced Participant 02's admission. According to her account, the psychiatrist initially proposed that she return home with medication, but her sister and a nurse insisted on hospitalization. In this case, there was an alternative to admission that was ultimately not followed.

In other cases, the concern was the circumstances in which the decision was made. Participant 04 arrived at the emergency department after a suicide attempt and recalls confusion, drowsiness, and memory gaps. She does not remember agreeing when the psychiatrist announced that she would be admitted. Her account cannot establish the full procedure, but makes clear that she does not see it as a decision she made.

The absence of resistance does not necessarily mean that the person chose to be admitted either. Participant 05, who was hospitalized as an adolescent, describes an imposed decision, even though she did not oppose it. She was also unaware of some of the conditions of the stay, such as being watched while using the bathroom. This experience points to the importance of explaining in advance what will happen during care, a right that the Mental Health Law recognizes alongside information about alternatives and risks (Congress of the Republic, 2019, arts. 9.2–9.3).

Experiences also differed among those who agreed to admission. Participant 07 initially resisted, then agreed after pressure from people close to him and those involved in his care, who described the facility as a "spa". His eventual agreement does not erase that pressure or the gap between what he expected and what he encountered.

Unlike her first admission, Participant 06 sought a second hospitalization voluntarily, but says she did not know what care would be like. Participant 09 also sought admission herself and signed a voluntary admission form at a private clinic, without knowing how the facility operated or how she would be treated.

These choices should be acknowledged, while **recognizing that people lacked information necessary for a truly informed decision.** This is also apparent in Participant 10's hope of finding peace and in Participant 08's experience. In all these cases, seeking help or agreeing to care did not amount to fully informed consent: people did not know in advance what the conditions would be, what restrictions they might face, or how their rights would be affected.

Together, the interviews show why consent cannot be reduced to a signature or a lack of resistance. **It is essential to establish whether the person understood the proposed care, knew about alternatives, and could agree or refuse without pressure.** WHO and OHCHR's guidance on person-centered care free from coercion requires these decisions to carry real weight (WHO & OHCHR, 2023). Family concerns and professional recommendations should support this process by ensuring timely, appropriate information and the support people need to make their wishes heard.

5.2 Living in custody: the loss of autonomy during institutionalization

Going to the bathroom, choosing what to wear, talking to someone, or reading a book are everyday decisions. During institutionalization, many interviewees lost the ability to make these choices for themselves. Staff controlled their schedules, monitored them, and required permission for basic activities. **Control reached into private spaces and the most ordinary actions, contrary to the right to care in the least restrictive environment and the person-centered approach set out in Peruvian regulations and international standards** (Congress of the Republic, 2019, art. 9.6; WHO & OHCHR, 2023).

One of the first restrictions was on contact with the outside world. Participant 01 spent more than two years without a telephone or internet; Participants 02, 05, and 06 recall having their cell phones taken away. Participant 03 could not communicate outside of visits, and Participant 09 describes an initial period of isolation, without communication. **These measures limited the possibility of maintaining relationships and telling someone they trusted what was happening inside the facility.** Article 22 of the CRPD protects privacy, family life, and communications from arbitrary or unlawful interference, regardless of where the person lives (United Nations, 2006).

Control also extended to day services. Participant 08 stayed at her aunt's home overnight, but staff took away her belongings at the center and required her to ask permission for basic activities. Depending on the treatment module, other participants had to accompany her to the bathroom. Returning home each evening did not mean she could make decisions freely while receiving care:

> ***'You're no longer going to be able to go out without permission. You can't go to the bathroom alone. You can't eat what you want, you can't choose your food. Of course, none of that, no, no, no.'***
>
> -Testimony of Participant 08

During hospitalization, restrictions could even extend to the possibility of having a moment of privacy. Participant 01 describes an internal hierarchy that determined what freedoms each person had. Participant 04 remembers locked doors, curtains she could not close without permission, and being unable to go to the bathroom at night. Participant 05 recounts that she was watched while bathing and that she used bathrooms without doors, conditions that had not been explained to her before admission:

> *They didn't explain it to me, but because we all went to the bathroom together, I thought, well, this is just how it works. I sort of accepted it, but they hadn't told me before I went in that it would be like that.*
>
> - Testimony of Participant 05

Over time, Participant 05 ended up getting used to these practices. However, adapting to the rules of a place does not mean having chosen them or feeling comfortable with them.

People also had little say over food and clothing. **Some recalled others deciding what they could eat or wear;** Participant 06 mentioned restrictions on clothing colors. Participant 04 had to eat quickly, ask permission to get her fruit, and wear a gown and slippers on walks, even though she had been brought sneakers without laces. Participant 05 also feared being given a feeding tube. QualityRights states that food and clothing should meet people's needs and preferences: these choices are part of care quality and respect for rights (WHO, 2012).

Rules also governed relationships. Participant 05 recalled that close friends could be separated, while Participant 07 was told not to make friends with anyone. During Participant 04's visits, even **crying could mean her relative had to leave.** A visit that might have offered comfort and companionship therefore depended on suppressing sadness:

> *The nursing technician said, 'No, nobody cries here; if you cry, you have to leave.' She told my dad he had to go.*
>
> - Testimony of Participant 04

People also faced restrictions on how they spent their time. Participants 05 and 10 described long periods without activities; Participant 09 exercised on her own initiative, and Participant 04 needed permission to read her books. Some experiences were positive: Participant 03 valued the occupational activities and time outdoors.

Amid the restrictions, the company of other people helped them cope with the stay. Participant 09 found support among her peers and kept in touch with them, even though this was prohibited:

> *There was a group of people inside the center who helped me a lot to get through it.*
>
> - Testimony of Participant 09

These accounts show that restrictions on autonomy permeate everyday life, from maintaining friendships and expressing sadness to choosing activities and using the bathroom in private. QualityRights (2012) calls for assessing both care quality and respect for rights in residential and outpatient settings. **Providing care is not enough: services must examine whether their rules and practices respect dignity and allow people to maintain their relationships, preferences, and choices.** Care quality also depends on people having real control over their lives, including the most ordinary aspects.

5.3 When treatment and medication become a form of control

Across the ten accounts, a recurring finding is that institutions treated people's needs as if they were the same. As Participant 02 describes, care routines and even medication tended to be uniform regardless of diagnosis, personal history, or stage of life, rather than guided by an individualized plan.

> *We all got pills, but it felt like we were all getting the same ones. Everyone would say, 'Oh yes, there's the pink one, the whatever-it-is.' It was like we were all taking valproate, others quetiapine. You have to trust what they give you too. (...) When you're in there, you just take what they give you. Once you're out, you look things up and get explanations.*
>
> - Testimony of Participant 02

This uniform approach conflicts with the principle of person-centered care that, at least in regulation, is central to CSMCs and supported homes (Section 4.1). The relevant regulations require an Individualized Care Plan for each service user (Health Technical Standard for Supported Homes, Ministerial Resolution No. 701-2018/MINSA).

Several accounts describe how this approach shaped daily life: fixed schedules, repetitive routines with no room for individual choice, and arrangements focused more on managing

facilities and staff than on each person's therapeutic needs. This pattern is consistent with the CRPD Committee's 2023 concluding observations on Peru, which expressed alarm at the absence of a deinstitutionalization strategy and recommended prohibiting coercive treatment, including seclusion and restrictive practices (United Nations, Committee on the Rights of Persons with Disabilities, 2023).

Related to this uniform approach was the placement of people with widely differing experiences and support needs in shared institutional spaces. Interviewees described sharing facilities with people who had committed crimes such as homicide or rape, including some found not criminally responsible, as well as people experiencing different levels of emotional distress. Where these arrangements did not take individual needs into account, several interviewees described fear, anguish, and increased distress. Their accounts highlight the need to recognize different support needs and provide living conditions that protect everyone's well-being and rights.

The use of medication to control or sedate people, rather than as part of treatment agreed with them, is among the interviews' most sensitive findings. Several accounts describe medication given without clear explanations of its purpose, effects, or alternatives. Interviewees associated these circumstances more with controlling behavior than supporting recovery.

> ***They've never informed me about the medications. They never told me what effects they had or what they were for, or whether I agreed to take them. (...) It was all confinement and medication.***
>
> - Testimony of Participant 10

The CRPD Committee itself recommended that Peru guarantee informed consent in all mental health services and prohibit the administration of psychotropic drugs without consent (United Nations, Committee on the Rights of Persons with Disabilities, 2023), in line with the right recognized in Article 9.7 of Law No. 30947.

Finally, **the accounts reveal how physical health needs were systematically overlooked and subordinated to the management of mental health. In several cases,** physical ailments, specific dietary needs, and unrelated chronic conditions went unrecognized within the institution.

> *There's a set time when you have to sit down and eat whatever they serve you. Each plate has a name on it; they call your name, and that's what you have to eat. (...) If you have an allergy, or someone's vegetarian, they don't respect that. The nutritionist came just before I left, about two days before. I told her, 'Look, I have insulinemia. I don't know why they've put me on almost 3,000 calories.' (...) That's when she became concerned.*
>
> - Testimony of Participant 02

This directly contradicts the comprehensive approach recognized in Peru's own regulatory framework. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights establishes that the right to health includes underlying determinants such as food, housing, and living conditions. Community-based care is also defined, at least in policy, as comprehensive and continuous, inseparable from the person's wider health needs. **The gap between this principle and participants' experiences provides qualitative evidence of several management shortcomings documented in Section 4.2.**

5.4 Dignified treatment? Power dynamics, coercion, and mistreatment

The accounts reveal deeply unequal power relations within institutions. Staff set the rules of daily life, interpret people's behavior, decide what is acceptable, and often influence the conditions of their stay and discharge. **Coercive practices can thus become part of everyday institutional operations, serving to maintain control.**

Interviewees described **seclusion, threats, public confrontations, punishment, immobilization, and restraint.** Some experienced these directly; others witnessed their use on fellow residents. Their accounts indicate that such measures could form part of everyday life, requiring people to adapt to institutional rules regardless of their needs. Fear of the consequences of non-compliance also regulated behavior: people learned what they could and could not do, and what might happen if they challenged the rules

> *"They took me in and tied me to a bed by all four limbs, stretched out like that, tied really tight. I was like that for eight hours. It was in a special ward, the ICU, intensive care, where other patients were tied up too. There was a woman screaming that she needed the bathroom, but the nurses ignored her. I mean, even if you screamed, they didn't listen. The nurses were on their phones.*
>
> -Testimony of Participant 10

Coercion also worked in less visible ways. Some people recalled individual staff members treating them courteously or respectfully. Participant 04, for example, was moved by a nurse asking whether she wanted to keep reading before turning off the light. Yet the accounts suggest that treatment could depend on behavior: people who followed the rules, did not cause "problems", or cooperated could receive better treatment, while those who questioned rules or expressed distress could face tighter restrictions or coercion. **Courtesy could thus form part of a system that rewarded compliance.**

Regaining freedom could also depend on convincing those in authority that one was sufficiently "well". Several participants described learning to "pretend to be well" so that expressions of distress would not be interpreted as deterioration, prolonging their stay or bringing further restrictions. Participant 09, admitted to a private facility, illustrates this dynamic:

> *Once I'd seen this reality I knew nothing about–how these centers worked (...)–I thought, well, I have two options. One is to say, 'I want to leave, get me out of here.' They'd told me that was the worst thing you could do, because the doctor would obviously say, 'No, she's crazy.' Anything becomes a sign that you're not well. Or I could cooperate, right? So I chose the second option. And I pretended a lot. I remember pretending so they'd let me out, because I was afraid they'd say, 'No, she's getting worse,' or take anything as a sign of that. So I put on a really good performance for my psychiatrist, and eventually they discharged me.*
>
> - Testimony of Participant 09

This reveals a **fundamental contradiction: instead of offering a place to express distress and receive support for recovery, an institution could give people reasons to conceal it.**

The testimonies show the extent to which this situation could generate desperation. In a context where people had little room to decide on fundamental aspects of their own lives, the desire to regain their freedom could become so intense that some were willing to put their own lives at risk to get out of the institution:

> ***I remember they brought in a boy of about 15 because of an addiction–I don't remember whether it was gaming or what. He swallowed a spoon so they'd take him out. He knew they couldn't operate on him there, so he thought, 'What do I do? I'll swallow a spoon.' He did it so they'd take him out of the center and somewhere else. He could have died; he could have choked. (...) He took that risk: 'I'll risk my life. I want them to get me out of here. I'm desperate; I can't stand being here.' That's how desperate he was... and he hadn't even been there a week.***
>
> - Testimony of Participant 01

This episode is particularly significant because the interviewee does not necessarily attribute it to direct mistreatment by staff. It shows how being subjected to control can have severe consequences even without direct aggression.

Power relations could also be shaped by discrimination based on sexual orientation, gender identity, or gender expression. Interviewees described being singled out for restrictions and attempts to change people's gender expression or sexual orientation, known as conversion practices. Participant 01 witnessed these practices in a private institution with an evangelical Christian orientation. Participant 07, meanwhile, reported being subjected to different restrictions from the moment he was admitted to a public hospital, on the grounds of his sexual orientation:

> ***They made what they called adjustments 'for my own good, for my comfort,' but they were homophobic adjustments. (...) She said, 'Those are the rules, but because we know about your sexual preference, we've given you a room of your own so you won't feel uncomfortable.' (...) 'Everyone respects each other, but to avoid any discomfort for you, the nurse will let you know when you can shower, after all the other boys have showered.' (...) Why do I have to shower after all the men? (...) So, as part of their daily routine, they're going to take the time to tell the little faggot sleeping alone in his room that he can shower, making sure he doesn't share the space everyone else gets to use.***
>
> - Testimony of Participant 07

These accounts show how institutionalization, presented as protection or care, often restricts rights and reproduces discriminatory stereotypes. **Where alternatives are absent, accepting these conditions can become the price of treatment.** This deepens power imbalances: when an institution appears to be the only option, even service users may come to tolerate discriminatory practices.

Together, the findings suggest that **institutionalization can function as a means of controlling people's lives, behavior, and decisions** rather than supporting care, treatment, and recovery. Coercion can be physical or punitive, but it can also shape what people feel able to say, leading them to hide distress or even their identity to secure discharge. Even without evident staff mistreatment, the power structure itself can cause anguish, subordination, and loss of autonomy.

5.5 Institutionalization as a response to a system without alternatives

Most accounts describe **institutionalization as the outcome of a chain of structural failures in the mental health system,** rather than an isolated clinical decision. Several people saw admission as a last resort after exhausting–or never having access to–community care alternatives.

> ***"At first I said no. But then the psychologist told me, 'This is your last option. There's nothing else.'***
>
> -Testimony of Participant 07

This sense of "having no other option" described by the interviewees reflects, in their own lives, the coverage gaps in the mental health system documented in Section 4.

Several accounts also describe misdiagnosis or delayed diagnosis on the path to institutionalization. This led to treatment that did not meet people's actual needs or delayed access to appropriate care.

> *I'd already had several crises and sought care at different times (...) First I was wrongly diagnosed with BPD, then with bipolar II, and I've also questioned how the system has understood my mental health experience. There's a lot of prejudice and gender bias, and that can mean women's experiences are interpreted differently and we're given certain diagnoses more readily.*
>
> -Testimony of Participant 06

Although this account cannot establish the scale of the problem nationally, it is consistent with the shortage of specialized staff described in Section 4.2. **It illustrates how gaps in the system affect timely access to diagnosis and treatment.**

A third recurring theme is the absence of family, social, or institutional support when people most needed it. Several interviewees described estrangement from or a lack of family, alongside the absence of social or community networks that might have offered an alternative to institutionalization. This connects with the limited integration of community health workers and mechanisms for lived experience participation documented in Section 4.2, despite their central place in the model. The absence of family support described by interviewees suggests that this gap is felt directly in people's lives, beyond shortcomings in institutional design.

Institutionalization also had lasting effects beyond the admission itself. Common consequences included interrupted education or employment, weakened or lost family and social ties, and difficulty rebuilding an autonomous life after discharge.

> *Being institutionalized has definitely affected how I feel about my social life now. When I got out after two and a half years, it was really hard to find my place again, and it still is. Basically, they take away all your autonomy, your ability to decide for yourself, then say, 'Okay, now go and get it back however you can.' (...) That's why I hate them. (...) They bear the greatest responsibility, because I think you should be able to expect a psychiatrist to understand the long-term psychological consequences of admitting someone (...) In my own experience, I feel I've developed certain tendencies, even somewhat more antisocial ways of thinking. I've lost a good part of my innocence.*
>
> - Testimony of Participant 01

Este hallazgo conecta directamente con el marco de derechos que titula este informe: el derecho a vivir en comunidad, reconocido en el artículo 19 de la CDPD, no se agota en el momento del egreso de una institución, sino que exige condiciones sostenidas para que la persona pueda reconstruir su proyecto de vida con autonomía. **La evidencia cualitativa de esta sección sugiere que, incluso cuando la institucionalización termina formalmente, sus efectos continúan moldeando las oportunidades y decisiones de las personas durante años.**

5.6 What needs to change? Proposals informed by lived experience

The experiences documented in this study show that rights violations, restrictions on autonomy, and coercive practices are not isolated incidents or simply the failings of individual staff members. The institutional model is built around unequal power relations, subordinating people's needs, preferences, and decisions to institutional rules and routines, staff convenience, and–in private facilities–financial interests and profit. The accounts consistently **describe how places intended to support recovery often become traumatizing environments that deepen the distress and suffering they should help relieve.**

> *In my case, I feel I came out worse than I went in. You're supposed to go somewhere like that for help, to heal, but my experience was the complete opposite. That's why I think things have to change. It's about creating places where people can really heal, where their autonomy is respected, where they can make their own decisions and live in the community, instead of keeping them under control. In the end, they're supposed to help you get better, not leave you worse off than when you arrived.*
>
> – Testimony of Participant 06

> *They really are places with no intention of helping you recover. (...) I've come to hate the way the place is set up, how it runs like a business, how it profits from the family's needs.*
>
> -Testimony of Participant 01

In this context, the interviewees' proposals aim to transform the ways in which mental health problems are understood and addressed, as well as to strengthen community-based supports.

A recurring demand is to **recognize people with lived experience, especially of institutionalization, as essential sources of knowledge for transforming mental health services and policy.** Interviewees challenged the exclusion of their experiences, needs, and perspectives from policy decisions.

> ***Laws should be made with people, because sometimes they [the doctors] have no idea. (...) They don't take people seriously because they think they're 'gallina turuleca' [a colloquial expression suggesting someone is crazy], as my sister sometimes says.***
>
> -Testimony of Participant 02

Participation must have an impact: inviting people to consultations is insufficient if their contributions do not affect the final decisions. People also need safe ways to criticize services and report violations without fear of reprisals. **Bringing lived experience into service design, implementation, and evaluation would help build responses that respect autonomy and better meet service users' needs.**

> ***I feel that white, privileged people sit down and do all these things in the community's name, but they never sit down to talk to the community. They come to impose things, and there's no real dialogue. (...) That dialogue with people with psychosocial disabilities, with neurodivergent people, is missing. We're not listened to; we're not taken into account.***
>
> – Testimony of Participant 04

Interviewees also called for **stronger institutional oversight and effective mechanisms** to protect rights. Proposals included unannounced inspections, particularly in emergency services, and ways to hear directly from institutionalized people and those receiving outpatient care. Oversight must examine how people are treated, medication management, food, and restrictions on freedom and decision-making, alongside buildings and physical conditions.

> *In general, the centers need oversight. (...) I feel there's no oversight at all. And in the end, because you're a patient, if you have no say, they can really do whatever they want with you, right?*
>
> -Testimony of Participant 08

Added to this is the need for regulations, accessible complaint channels, and accountability mechanisms to prevent and respond to potential violations. Staff training and the adaptation of spaces to different needs are also essential.

Deinstitutionalization also requires accessible, ongoing community alternatives tailored to each person's needs and preferences. The accounts show that the presence of CSMCs does not, on its own, ensure appropriate care or access for those who need it. Access difficulties, staff turnover, limited care options, interrupted treatment, and administrative barriers can undermine therapeutic relationships and cut off essential support.

> *I'm very critical of how mental health is handled in general, not just institutionalization, but even community centers. (...) Basically, the care I got there was to receive medication, because the psychological counseling... Community centers often use cognitive behavioral therapy, which can help with some things, but some of us overthink a lot and it doesn't work for us. I need a different kind of therapy. Unfortunately, I feel that just isn't available in the free public psychological services.*
>
> -Testimony of Participant 01

Community services must therefore be strengthened, with continuity of care, outpatient alternatives, early intervention, and support networks at home and in the community. **Families also need support, and crises should not lead automatically to admission because no other response is available.** Although interviewees differed in their views of institutionalization, their experiences emphasize the need for appropriate alternatives and decisions that reflect each person's circumstances and preferences.

These changes must also recognize that **leaving an institution does not automatically restore freedom, autonomy, or full participation in society.** Stigma surrounding mental health problems and hospitalization can extend confinement in other forms: rejection, mockery, mistrust, and fear of sharing one's story or not fitting in.

> ***The psychologist tells me, 'I suggest you don't go back to working with children, because we don't know what might happen, how you might react,' something like that. (...) They plant these doubts in your mind. (...) It hurts when my sister says, 'Are you taking your medication? Otherwise you'll be the gallina turuleca' [a colloquial expression suggesting someone is crazy]. Things like that don't help; they damage your self-esteem."***
>
> -Testimony of Participant 02

Discharge is not enough if people still face barriers to rebuilding relationships, studying, working, or participating in their communities. **Participants therefore call for concrete action against stigma,** recognizing people with lived experience as rights holders who can make decisions, contribute to society, and help transform services.

Finally, **the testimonies gathered challenge an understanding of mental health that, in practice, remains focused exclusively on the individual and on clinical treatment.** Exposure to violence, the family environment, access to education and housing, working conditions, safety, and economic inequities are part of the circumstances that shape people's lives, affecting their mental health and their possibilities for recovery.

> ***Mental health is a structural issue. It's not just about individuals sorting out their personal problems. You have to give people health care, a good education, safe streets, decent housing, and decent work if you want them to be emotionally healthy. That's what we need to keep working on.***
>
> - Testimony of Participant 01

> ***I think talking about mental health also means looking at everything going on in someone's life. (...) So many things have an influence: family, surroundings, relationships, the conditions we live in. I think all of that should be taken into account when we think about mental health.***
>
> - Testimony of Participant 06

Socioeconomic inequalities and unequal access to resources and opportunities also shape people's chances of recovery and of building a life in the community. Being able to afford psychotherapy, see specialists, continue treatment, or access education and employment can make a substantial difference to the course of people's lives.

> ***I'm keeping up with therapy; I've gone back to seeing my psychologist every week. (...) For now I'm quite stable and doing really well, luckily. (...) I know I have a lot of privileges, and that's helped me get to where I am today. Unfortunately, not everyone has that, and it makes me very sad.***
>
> -Testimony of Participant 09

Recovery and the right to live in the community therefore require accessible services, as well as social and community-based supports that respond to each person's needs.

These proposals call for changes to both institutions and the social conditions that limit autonomy and participation. **People with lived experience are more than recipients of care and protection: their knowledge must be central to building a system that respects their rights and enables them to live in the community.**





Image: Andina

6 The current situation: Threats to deinstitutionalization in Peru

6.1 The slowdown in the community-based reform and its contributing factors

As previous chapters show, **Peru's community-based mental health reform still faces substantial gaps in implementation and coverage.** These limit the model's reach and are reflected in the pace of service expansion, a key measure of whether the reform is being sustained.

When this study was prepared, Peru had 306 CSMCs and 94 supported homes (DSAME, 2026a). As for CSMCs, this figure is equivalent to 60% of the 506 centers the State had set out to reach by 2026 (MINSA, 2021). Meanwhile, the National Plan for Strengthening Community Mental Health Services 2018–2021 set a target of establishing 170 supported homes by 2021 (MINSA, 2018). **Yet five years after that deadline, the country has reached barely 55% of the target**. Taken together, these figures reveal substantial and persistent gaps in the expansion of both components of the community mental health network.

The COVID-19 pandemic provides important context. Peru was among the countries hardest hit, recording one of the world's highest per capita mortality rates from the virus (JHU, 2022). The emergency put extraordinary pressure on the health system and required resources and institutional capacity to be redirected toward the immediate response. This may have disrupted other health policies, including the development of community-based mental health care.

Political instability has added to these pressures. Peru has had nine presidents in ten years, disrupting continuity in policy priorities and making long-term structural reform harder to sustain. Community-based mental health reform is particularly dependent on sustained planning, continuity in management teams, and political commitment to maintain investment and expand services over time.

The slowdown is evident in recent CSMC expansion. In 2022, the network grew from 208 to 248 centers, with 40 openings (MINSA, 2022). This fell to 27 in 2023 and 13 in each of 2024 and 2025 (MINSA, 2023, 2025a, 2025b). Annual openings therefore **fell by 67.5% between 2022 and 2024,** from 40 to 13, and remained at that level in 2025.

The slowdown continued into 2026. By September, only five centers had been added since 2025 (DSAME, 2026a). **This was 61.5% fewer than the previous year's openings and 87.5% fewer than in 2022.** These challenges in expanding services are compounded by limited mental health funding, which accounts for just 2.1% of the health sector budget (MEF, 2026).

These data do not establish that the political context directly caused the slowdown, but they show a **significant loss of momentum with implications for the reform's continuity and sustainability.** Instability remains relevant to understanding the conditions for policies that require long-term planning and investment. MINSA's institutional evaluation for 2024 illustrates this: frequent changes in directors and management teams in Lima and other regions disrupted administrative processes needed to operate and expand services, including purchasing goods and equipment, as well as recruiting staff (MINSA, 2025c).

These gaps must also be understood against Peru's changing political and legislative context. The year 2026 has brought presidential, legislative, regional, and municipal elections, alongside growing political division and polarization. Examining these developments helps assess the conditions that may support or undermine the continuation of community-based mental health reform.

6.2 Political and legislative developments

Political polarization and fragmentation are growing in Peru and across Latin America. Regional polarization has risen steadily over the past two decades, accelerating particularly since 2015 and making Latin America one of the world's most polarized regions (UNDP, 2023). In Peru, UNDP reports a political polarization score of 3.9 out of 4 for 2023–2024, the highest in two decades (UNDP, 2025). This makes it harder to build agreements and sustain policies that require consensus beyond elections and changes of government.

Polarization becomes particularly consequential when political divisions extend to human rights. International bodies have warned that shared commitments to human rights are increasingly being challenged in several countries in the region. The IACHR has highlighted the spread of rhetoric that downplays or denies human rights violations and the resulting risks to effective protection (IACHR, 2025).

Mental health policy, particularly deinstitutionalization, is affected by these dynamics. **Although community-based reform rests on human rights obligations and international standards that should transcend party politics, it can become politically contested.** Elections offer a useful way to examine how different political groups approach these issues and address them in their policy platforms.

Peru's 2026 general elections illustrate the fragmentation of the political landscape: 36 political organizations fielded presidential candidates. Given this diversity of proposals, it is important to analyze what place mental health—and, specifically, the continuity of the community-based mental health reform—occupies on the agendas of political organizations.



De-Mentes (2026) analyzed the government plans submitted by the 36 political parties to the National Jury of Elections (Jurado Nacional de Elecciones). Although mental health appeared in many government plans, mentions did not necessarily translate into specific commitments. Twenty parties (56%) mentioned mental health at least once, but **only 12 (33%) included a specific indicator, target, or commitment.** Fourteen (39%) proposed measures to strengthen mental health service reform, while only four (11%) proposed increasing funding or improving its use.

Other core elements of community-based reform received similarly limited attention. Only 12 government plans (33%) included cross-sector proposals addressing social determinants of mental health; nine (25%) proposed measures specifically for children and young people; and five (14%) included mechanisms for public participation in developing or improving mental health policy. Thus, while mental health is gaining a place in political debate, **its priority varies considerably, particularly when it comes to the commitments needed to sustain and deepen structural reform.**

These differences are expressed not only in the proposals that political organizations decide to include in their government plans, but also in legislative initiatives that may influence the progress of the reform. One example is **Bill No. 4324/2022-CR, enacted as Law No. 32697 in July 2026.** Introduced by the Acción Popular parliamentary group, it proposed amending Law No. 29973, the General Law on Persons with Disabilities, to **establish temporary and permanent shelters for persons with disabilities.** Congress initially passed the bill in April 2025 with 83 votes in favor and one abstention. Following opposition and advocacy by civil society, the Executive returned it with objections in May 2025.

The Executive's objections identified conflicts with existing legislation: the Mental Health Law, which places deinstitutionalization and community-based care at the center of policy; the General Health Law, which prioritizes outpatient care and care in family, educational, and community settings; and Article 19 of the CRPD, which recognizes the

right to live independently and be included in the community. Congress's Committee on Social Inclusion and Persons with Disabilities[1] then had to consider the Executive's response and choose among the available legislative options: shelve the bill, make substantial amendments in response to the objections, or recommend passing it over those objections, unchanged or with minor amendments.

During this process, organizations of persons with disabilities, family members, and mental health organizations–including those behind this research–publicly raised concerns and engaged in dialogue with Congress. They proposed stronger support for community living, including personal assistance, home-based and residential support, respite services for family caregivers, and other measures to uphold autonomy and social inclusion. These proposals rest on a different premise: supporting people with disabilities and their families require services that enable community living, rather than new forms of institutionalization.

The UN echoed these concerns. In November 2025, OHCHR experts warned that the proposal would set back Peru's efforts toward deinstitutionalization and independent living. They highlighted the risks of deprivation of liberty, violence, abuse, and neglect, and questioned the lack of meaningful consultation with persons with disabilities and their representative organizations (OHCHR, 2025).

Despite these objections and civil society advocacy, a committee recommendation to pass the bill over the Executive's objections was placed on Congress's final plenary agenda before the change of government in June 2026. The only amendment removed the reference to "permanent" shelters, retaining "temporary" shelters. Congress passed it by a large majority on June 24, and it was published as Law No. 32697 in the official gazette El Peruano on July 4, 2026.

The law exposes a fundamental tension in Peruvian policy. While mental health reform seeks to advance community services, deinstitutionalization, and support for community living, **the new legislation again allows segregation as a response to the needs of persons with disabilities.** This is particularly concerning given the long record of neglect, overcrowding, deteriorating infrastructure, and rights violations documented in long-stay facilities by the Ombudsman's Office (2005, 2009, 2018, 2025) and the Office of the Comptroller General (2025a, 2025b).


Image: Ombudsman's Report 180, Office of the Ombudsman.

Amid growing polarization and political challenges to human rights, the law's passage shows how fragile the consensus supporting community-based mental health reform has become. **When proposals conflicting with national legislation and Peru's international commitments advance through Congress, they raise wider questions about the State's ability to protect and sustain the reform.**

The reform's future depends on expanding services and sustaining progress, but also on the State's ability to uphold autonomy, inclusion, and community living through political and legislative change. This brings us to what is at stake for mental health and deinstitutionalization in Peru.

[1] With the introduction of a bicameral Congress in July 2026, the committee structure no longer includes a committee explicitly named for persons with disabilities (Congress of the Republic of Peru, 2025, 2026). In the Chamber of Deputies, these issues fall within a committee with a broader remit. This raises concerns that their rights may lose institutional visibility and that people with lived experience may face additional barriers to participation in the legislative process.

6.3 What is at stake

The experiences gathered in this study reveal the profound consequences that institutionalization can have on people's autonomy, relationships, identity, and exercise of rights. Furthermore, the context analyzed in this chapter shows that **these risks can be heightened in settings of political instability, polarization, and growing debate on human rights.** The consensus that sustains systemic reforms, such as the community-based mental health reform, can weaken and open the way to responses that had already been challenged because of their effects on people's lives and dignity.

Argentina offers an important warning. Its community-based mental health reform has had a legal framework since 2010. Yet in 2026, more than 150 organizations representing persons with disabilities, service users, families, and human rights advocates warned that a proposed amendment to the National Mental Health Law would restore elements of institution-centered care and weaken the right to community living (Asociación Civil por la Igualdad y la Justicia, 2026). If a consensus built over more than fifteen years can be challenged in a country with a longer history of reform, **Peru cannot take its own progress for granted.**

Defending deinstitutionalization requires an informed public and engagement from civil society, academia, professionals, the media, and the international community to support the State and hold it to its commitments. People who have experienced institutionalization must be central to this process. Their accounts are essential to understanding the system's risks and guiding future policy decisions.

At stake is more than the continuity of a policy: it is Peru's ability to uphold the principle that everyone has the right to live in the community with autonomy, support, and dignity, regardless of the political climate. **Slowing reform, fragile implementation, and legislation that undermines progress make stronger advocacy and oversight urgent.** The conclusions and recommendations that follow address what the State and society must do to establish deinstitutionalization as a lasting commitment to everyone's mental health and human rights, rather than one dependent on the political moment.

7. Conclusions

Deinstitutionalization fundamentally transforms mental health care and support. It means moving from a system based on long stays in psychiatric hospitals to community-based models that uphold human rights, autonomy, and people's participation in decisions about their own lives.

This requires more than closing institutions, reducing beds, or moving care to smaller or community-based facilities. **Health systems, power relations, care practices, and the social conditions that restrict freedom and community living must change.** As this study shows, the way institutions operate creates unequal power relations that can restrict autonomy, enable coercion, and violate fundamental rights. Deinstitutionalization is therefore, above all, a human rights issue.

Recent decades **have brought growing international consensus on the need for community-based mental health and support systems grounded in human rights.** The CRPD, WHO guidance, and other international standards recognize the importance of upholding the right to independent and community living and transforming services and practices that perpetuate segregation.

In Peru, this approach has informed a reform that, since 2012, has laid the foundations for community-based mental health care. The country has developed legal and technical frameworks intended to transform care and uphold human rights, enabling the development of services that bring care closer to communities.

Yet **this study reveals a persistent, significant gap between legal commitments and people's experiences.** Mental health institutions continue to restrict freedom and autonomy through care without informed consent, imposed decisions about treatment and medication, and other forms of coercion and control. The accounts show that **institutions can become places of rights violations and retraumatization rather than recovery and well-being.** People with lived experience also have limited meaningful involvement in designing, implementing, and evaluating the policies and services that affect them. This makes responses less relevant and perpetuates the power relations the reform should transform.

The gaps extend beyond institutions. **Community services are a major step forward, but structural barriers persist** in infrastructure, service availability, geographic distribution, staffing, and continuity of care. These hinder timely, sustained access to the support people need to live in the community. The

slowdown in reform in recent years is therefore especially concerning. A favorable legal framework alone does not guarantee changes in practice or sufficient, accessible community alternatives that respect human rights.

Peru's **fragmented health system further complicates a coordinated transformation of care.** Subsystems with different governance and funding structures do not necessarily advance at the same pace. Deinstitutionalization must extend beyond services run by MINSA, with effective coordination between institutions and strategies to develop community-based services and supports across the health system and ensure access to them.

Public information for monitoring and evaluating the reform also remains limited. No public information on progress under the National Plan for Strengthening Community Mental Health Services 2024–2028 was found, or systematic data on the types of care provided, community health worker participation, or the proportion of people who remain institutionalized. These gaps limit the ability of civil society, academia, and oversight bodies **to assess whether the State is meeting its commitments, identify inequalities, and demand corrective action.** Without systematic, disaggregated public information, it is difficult to establish whether the reform reaches those who most need community-based services and supports, or whether funding and policies are helping uphold the right to live in the community.

These challenges arise **amid polarization and challenges to fundamental human rights commitments in Peru and across Latin America.** Law No. 32697, enacted in July 2026, is a concrete example of this backward movement. It raises serious concerns about reinforcing segregation and institutionalization, in conflict with Peru's mental health legislation and international commitments. Such initiatives **threaten more than a decade of progress** and risk reinstating responses that evidence and international standards have challenged for their effects on autonomy, dignity, and rights.

Peru's current challenge is to prevent the progress achieved from being reversed and to ensure that it translates into effective changes in people's lives. This requires sustained funding and stronger community-based services and supports, changes to institutional practices that violate rights, participation by people with lived experience, and legislative and policy decisions consistent with the State's international obligations. Deinstitutionalization is an ongoing process of structural transformation. Its legitimacy and success depend on people being able to exercise autonomy, make decisions about their lives, and receive the support they need to live in the community with dignity and equality.

8. Recommendations

8.1. Central and Regional governments

- **Strengthen oversight of mental health services and ensure public access to transparent information.** Led by MINSA, the State must strengthen rights-based inspection, oversight, and accountability across all mental health facilities and services. This requires an integrated public information system with up-to-date, disaggregated, comparable data. Authorities should publish regular monitoring reports and expand the Mental Health Observatory's indicators to include public and private providers across the different health subsystems.

- **Ensure adequate, steadily increasing public funding aligned with community-based reform.** Public investment in mental health must be maintained and increased over time, with allocations that close existing gaps and move toward international standards. Increases must be accompanied by clear criteria for allocation, spending, and evaluation, prioritizing community services, support for independent and community living, social inclusion, and deinstitutionalization.

- **Strengthen the mental health workforce, its geographic distribution, and its training through a human rights approach that responds to local needs.** MINSA and regional governments must adopt sustained strategies to reduce staff shortages and improve distribution, particularly in areas with limited access. This requires more initial and continuing training for interdisciplinary teams in community-based care free from stigma, recovery, community-based rehabilitation, informed consent, supported decision-making, and prevention of coercive practices. Incentives to recruit and retain staff in the regions and rural areas, together with working conditions that support continuity of care, are also needed.

- E**xpand support options for people and their families.** Transforming care requires a diverse support network that enables people to remain in their communities and choose how, where, and with whom to live. This should include personal assistance, support at home, community-based residential services, support for independent living, educational, social, and employment inclusion, and respite services for family caregivers.

- **Ensure meaningful participation by people with lived experience at every stage of reform.** In line with the State's obligations, current legislation, and international standards, permanent, accessible, adequately funded mechanisms are urgently needed for participation in policy and service design, implementation, monitoring, and evaluation. People must have the conditions to influence decisions, including accessible information, reasonable accommodation, remuneration where appropriate, and representation reflecting diverse experiences and geographic areas.

8.2. Congress and Senate

- **Review legislation and align it with the CRPD.** Congress and the Senate must review existing laws and legislative proposals on mental health, disability, and care services to identify and correct provisions incompatible with the CRPD and international human rights standards. This review must recognize persons with disabilities' legal capacity, autonomy, right to community living, and free and informed consent. Proposals must be assessed for their practical effects on these rights and must avoid reversing community-based reform.

- **Ensure effective participation by people with lived experience in the legislative process.** Congress and the Senate must establish permanent consultation and participation mechanisms that enable people with lived experience and their representative organizations to contribute meaningfully to drafting, debating, and evaluating legislation affecting their rights.



Image: Ministry of Health of Peru

8.3. Civil society, academia, and international cooperation partners

- **Strengthen independent monitoring of human rights.** Civil society must continue documenting and exposing rights violations in mental health services and barriers to autonomous community living. Academia and international cooperation partners can provide technical assistance, training, and resources for independent research, stronger monitoring capacity, and dialogue with public institutions.

- **Produce and share evidence on the implementation, gaps, and outcomes of community-based reform in Peru.** More research is needed on deinstitutionalization, living conditions in institutions, experiences of discharge, and barriers to community support. Universities, civil society organizations, and development cooperation agencies should support rigorous evidence that reflects geographic diversity and is developed with people with lived experience. Research should also compare legal progress and institutional commitments with actual practices and outcomes in people's lives.

- **Promote lived experience leadership in research, advocacy, and monitoring of the reform.** Recognize people with lived experience as rights holders, agents of change, and experts by experience. Support their equal participation in research design, knowledge production, the development of recommendations, and public policy evaluation.

8.4. The public

- **Help eliminate stigma and discrimination against people with mental health problems and psychosocial disabilities.** Transforming care also means challenging beliefs and practices that justify exclusion, segregation, and restrictions on rights. The public, media, educational institutions, and other groups can contribute by sharing accurate information and challenging prejudice.

- **Recognize everyone's right to live in the community and demand policies that make it a reality.** Deinstitutionalization requires commitment across society, beyond the health sector. An inclusive society must recognize that community living depends on services, resources, and social conditions that enable everyone to exercise their rights equally, as well as on individual choices and family support.

9. References

- Agencia Andina. (2020, October 15). *Se desarrollarán planes quinquenales para fortalecer servicios de salud mental comunitaria* [Five-year plans will be developed to strengthen community mental health services]. https://andina.pe/ingles/noticia-se-desarrollaran-planes-quinquenales-para-fortalecer-servicios-salud-mental-comunitaria-817815.aspx. Retrieved October 9, 2026.

- Asociación Civil por la Igualdad y la Justicia. (2026, May 11). *Carta al Senado de la Nación sobre el proyecto de reforma de la Ley Nacional de Salud Mental N.º 26.657* [Letter to the National Senate on the bill to reform National Mental Health Law No. 26,657]. https://a-cij.org.ar/wp-content/uploads/2026/05/Carta-al-Senado.pdf

- Berríos, M. (2023, June 11). *Hospitales del olvido: pacientes con trastornos mentales están abandonados por décadas* [Hospitals of oblivion: Patients with mental disorders have been abandoned for decades]. OjoPúblico. https://ojo-publico.com/4430/mas-160-pacientes-estan-abandonados-hospitales-salud-mental

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

- Castillo-Martell, H., & Cutipé-Cárdenas, Y. (2019). Implementación, resultados iniciales y sostenibilidad de la reforma de servicios de salud mental en el Perú, 2013-2018 [Implementation, initial results, and sustainability of the mental health services reform in Peru, 2013-2018]. Revista Peruana de Medicina Experimental y Salud Pública, 36, 326-333. https://doi.org/10.17843/rpmesp.2019.362.4624

- Committee on the Rights of Persons with Disabilities. (2014). *General comment No. 1 (2014): Article 12: Equal recognition before the law* (CRPD/C/GC/1). United Nations. https://-docs.un.org/es/CRPD/C/GC/1

- Committee on the Rights of Persons with Disabilities. (2017). *General comment No. 5 (2017) on living independently and being included in the community* (CRPD/C/GC/5). United Nations. https://docs.un.org/es/CRPD/C/GC/5

- Committee on the Rights of Persons with Disabilities. (2022). Guidelines on deinstitutionalization, including in emergencies (CRPD/C/5). United Nations. https://docs.un.org/es/CRPD/C/5

- Congress of the Republic. (2019). Ley N.º 30947, *Ley de Salud Mental* [Law No. 30947, Mental Health Law]. https://www3.congreso.gob.pe/Docs/DGP/DIDP/files/ley_30947.pdf

- Congress of the Republic of Peru. (2025). Reglamento de la Cámara de Diputados [Rules of Procedure of the Chamber of Deputies]. https://www3.congreso.gob.pe/Docs/comisiones2025/constitucion/files/reglamento-diputados.pdf

- Congress of the Republic of Peru. (2026, August 5). Pleno de la Cámara de Diputados aprueba número de integrantes de comisiones ordinarias [Plenary of the Chamber of Deputies approves the number of members of standing committees]. https://comunicaciones.congreso.gob.pe/noticias/pleno-de-la-camara-de-diputados-aprueba-numero-de-integrantes-de-comisiones-ordinarias/

- De-Mentes. (2025). *Brechas de financiamiento público en salud mental en el Perú* [Public funding gaps in mental health in Peru]. https://dementes.org.pe/wp-content/uploads/2026/06/Informe-de-investigacion-I-Brechas-financiamiento-publico-salud-mental-Peru.pdf

- De-Mentes. (2026). *¿Dónde está la salud mental? Un análisis de los 36 planes de gobierno en el Perú [Where is mental health? An analysis of the 36 government plans in Peru]*. https://dementes.org.pe/wp-content/uploads/2026/06/Donde-esta-la-salud-mental-Un-analisis-de-los-36-planes-de-gobierno-en-el-Peru.pdf

- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International Journal of Qualitative Methods, 5(1), 80-92. https://doi.org/10.1177/160940690600500107

- Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology. Organizational Research Methods, 16(1), 15–31. https://doi.org/10.1177/1094428112452151

- Inter-American Commission on Human Rights. (2025). Annual report 2024. Organization of American States. Official report.

- Johns Hopkins University of Medicine (JHU) - Coronavirus Resource Centre. (2022). Coronavirus Mortality Analyses. Johns Hopkins Coronavirus Resource Center. https://coronavirus.jhu.edu/data/mortality

- Leff, J., & Trieman, N. (2000). Long-stay patients discharged from psychiatric hospitals: Social and clinical outcomes after five years in the community. The TAPS Project 46. *The British Journal of Psychiatry, 176*(3), 217–223. https://doi.org/10.1192/bjp.176.3.217

- Mezzina, R., & Vidoni, D. (1995). Beyond the mental hospital: Crisis intervention and continuity of care in Trieste. A four year follow-up study in a community mental health centre. *International Journal of Social Psychiatry, 41*(1), 1–20. https://doi.org/10.1177/002076409504100101

- Ministerio de Economía y Finanzas. (2026). Seguimiento de la ejecución presupuestal (Consulta amigable) [Budget execution monitoring (User-friendly consultation portal)]. https://www.mef.gob.pe/es/seguimiento-de-la-ejecucion-presupuestal-consulta-amigable

- Ministerio de Salud. (2018). Plan nacional de fortalecimiento de servicios de salud mental comunitaria 2018–2021: Documento técnico [National plan for strengthening community mental health services 2018–2021: Technical document]. https://bvs.minsa.gob.pe/local/MINSA/4422.pdf

- Ministerio de Salud. (2021, December 10). *Minsa inauguró Centro de Salud Mental Comunitaria "Qispikay" en Puente Piedra* [Minsa inaugurated the "Qispikay" Community Mental Health Center in Puente Piedra]. Government of Peru. https://www.gob.pe/institucion/minsa/noticias/568854-minsa-inauguro-centro-de-salud-mental-comunitaria-qispikay-en-puente-piedr

- Ministerio de Salud. (2022, December 22). *CSMC San Borja recibió condecoración por constituirse en un servicio de salud eficaz y eficiente* [CSMC San Borja received an award for being an effective and efficient health service]. Government of Peru. https://www.gob.pe/institucion/minsa/noticias/682149-csmc-san-borja-recibio-condecoracion-por-constituirse-en-un-servicio-de-salud-eficaz-y-eficiente

- Ministerio de Salud. (2023, December 29). *Centro de Salud Mental Comunitaria Alto Puno beneficiará a más de 77 228 habitantes* [Alto Puno Community Mental Health Center will benefit more than 77,228 inhabitants]. Government of Peru. https://www.gob.pe/institucion/minsa/noticias/888788-centro-de-salud-mental-comunitaria-alto-puno-beneficiara-a-mas-de-77-228-habitantes

- Ministerio de Salud. (2024, October 15). Documento Técnico: "Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2024 – 2028" [Technical Document: "National Plan for Strengthening Community Mental Health Services 2024–2028"]. https://www.gob.pe/institucion/minsa/normas-legales/6094628-686-2024-minsa

- Ministerio de Salud. (2025a, January 5). *El Perú cuenta con 288 centros de salud mental comunitaria distribuidos en todo el país* [Peru has 288 community mental health centers distributed throughout the country]. Government of Peru. https://www.gob.pe/institucion/minsa/noticias/1086134-el-peru-cuenta-con-288-centros-de-salud-mental-comunitaria-distribuidos-en-todo-el-pais

- Ministerio de Salud. (2025b, December 31). *Minsa inaugura nuevo Centro de Salud Mental Comunitaria en Comas para beneficiar a más de 600 000 habitantes* [Minsa inaugurates new Community Mental Health Center in Comas to benefit more than 600,000 inhabitants]. Government of Peru. https://www.gob.pe/institucion/minsa/noticias/1324681-minsa-inaugura-nuevo-centro-de-salud-mental-comunitaria-en-comas-para-beneficiar-a-mas-de-600-000-habitantes

- Ministerio de Salud. (2025c). *Informe de evaluación institucional correspondiente al 2024* [Institutional evaluation report for 2024]. Government of Peru.

- Ministerio de Salud, Oficina General de Planeamiento, Presupuesto y Modernización [MINSA-OGPPM]. (2025, December). Programa Presupuestal 0131: Control y Prevención en Salud Mental. Reporte de seguimiento al III trimestre 2025 [Budget Program 0131: Mental Health Control and Prevention. Monitoring report for the third quarter of 2025]. https://www.minsa.gob.pe/presupuestales/doc2025/reporte-seguimiento/Reporte_PP_0131_2025_III.pdf

- Ministerio de Salud, Dirección de Salud Mental. (2026a, September). *Políticas públicas en materia de salud mental* [Public policies on mental health] [PowerPoint presentation].

- Ministerio de Salud, Dirección de Salud Mental. (2026b, October). Unpublished document provided in response to public information request No. 26-011605, dated September 30, 2026.

- National Institute of Mental Health "Honorio Delgado–Hideyo Noguchi" [INSM]. (2026). *Agentes comunitarios de salud salvan vidas al convertirse en el primer soporte de la salud mental en las zonas más vulnerables del Perú* [Community health workers save lives by becoming the first line of mental health support in Peru's most vulnerable areas]. https://www.gob.pe/institucion/insm/noticias/1401560-agentes-comunitarios-de-salud-salvan-vidas-al-convertirse-en-el-primer-soporte-de-la-salud-mental-en-las-zonas-mas-vulnerables-del-peru

- Office of the Comptroller General of the Republic [Contraloría General de la República]. (2025a). Informe de visita de control N.º 002-2025-OCI/0628-SVC, A la situación legal de los inmuebles que ocupan los centros de salud mental comunitarios [Control visit report No. 002-2025-OCI/0628-SVC, On the legal status of the properties occupied by community mental health centers]. Retrieved September 28, 2026.

- Office of the Comptroller General of the Republic [Contraloría General de la República]. (2025b). Informe de visita de control N.º 006-2025-OCI/0998-SVC, Hospital Víctor Larco Herrera [Control visit report No. 006-2025-OCI/0998-SVC, Víctor Larco Herrera Hospital]. Retrieved September 28, 2026.

- Office of the United Nations High Commissioner for Human Rights. (2025, November 27). P*eru: Disability law reform risks promoting institutionalisation, UN experts warn.* https://www.ohchr.org/es/press-releases/2025/11/peru-disability-law-reform-risks-promoting-institutionalisation-un-experts

- Ombudsman's Office [Defensoría del Pueblo]. (2005). Informe Defensorial N.° 102: *Salud mental y derechos humanos: La situación de los derechos humanos de las personas internadas en establecimientos de salud mental* [Ombudsman's Report No. 102: Mental health and human rights: The human rights situation of people hospitalized in mental health facilities]. Defensoría del Pueblo. https://www.defensoria.gob.pe/informes/informe-defensorial-no-102/

- Ombudsman's Office [Defensoría del Pueblo]. (2009). *Informe Defensorial N.° 140: Salud mental y derechos humanos: Supervisión de la política pública, la calidad de los servicios y la atención a poblaciones vulnerables* [Ombudsman's Report No. 140: Mental health and human rights: Supervision of public policy, the quality of services, and care for vulnerable populations]. Defensoría del Pueblo. https://www.defensoria.gob.pe/informes/informe-defensorial-no-140/

- Ombudsman's Office [Defensoría del Pueblo]. (2018). Informe Defensorial N.° 180: *El derecho a la salud mental: Supervisión de la implementación de la política pública de atención comunitaria y el camino a la desinstitucionalización* [Ombudsman's Report No. 180: The right to mental health: Supervision of the implementation of the public policy on community-based care and the path to deinstitutionalization]. Defensoría del Pueblo. https://www.defensoria.gob.pe/informes/informe-defensorial-no-180-derecho-a-la-salud-mental/

- Ombudsman's Office [Defensoría del Pueblo]. (2025). *Informe Defensorial N.º 233: Supervisión nacional de la implementación de Hogares Protegidos. Servicios de salud mental para la desinstitucionalización* [Ombudsman's Report No. 233: National supervision of the implementation of Protected Homes. Mental health services for deinstitutionalization].

- Ombudsman's Office [Defensoría del Pueblo]. (2026, January 13). Defensoría del Pueblo deplora reducción de presupuesto para abordar la salud mental [Ombudsman's Office deplores budget cut for addressing mental health]. Defensoría del Pueblo

- Pan American Health Organization. (2020). Funciones esenciales de la salud pública en las Américas: una renovación para el siglo XXI [The essential public health functions in the Americas: A renewal for the 21st century].

- Pan American Health Organization [PAHO]. (2023). Avances y desafíos de la reforma de salud mental en el Perú en el último decenio [Progress and challenges of the mental health

reform in Peru over the last decade]. https://iris.paho.org/bitstream/handle/10665.2/58312/OPSPER230004_spa.pdf

- Patel, V., et al. (2018). *The Lancet Commission on global mental health and sustainable development.* The Lancet, 392(10157), 1553–1598.

- Porsdam, S., Bradley, V. J., & Sahakian, B. J. (2016). Human rights-based approaches to mental health: A review of programs. Health and Human Rights, 18(1), 263–276. https://www.hhrjournal.org/2016/05/24/human-rights-based-approaches-to-mental-health-a-review-of-programs/

- Rocha, H. A. da, Reis, I. A., Santos, M. A. C., Melo, A. P. S., & Cherchiglia, M. L. (2021). Psychiatric hospitalizations by the Unified Health System in Brazil between 2000 and 2014. *Revista de Saúde Pública, 55,* Article 14. https://doi.org/10.11606/s1518-8787.2021055002155

- Sugiura, K., Mahomed, F., Saxena, S., & Patel, V. (2020). An end to coercion: Rights and decision-making in mental health care. *Bulletin of the World Health Organization, 98*(1), 52–58. https://doi.org/10.2471/BLT.19.234906

- United for Global Mental Health. (2025). Out of sight, out of mind: The human rights case for ending institutionalisation in mental healthcare. https://unitedgmh.org/app/uploads/2025/07/Out-of-sight-out-of-mind-1.pdf

- United Nations. (2006). *Convention on the Rights of Persons with Disabilities.* https://www.un.org/disabilities/documents/convention/convoptprot-s.pdf

- United Nations Development Programme. (2023, February 28). "Conmigo o en mi contra": La intensificación de la polarización política en América Latina y el Caribe ["With me or against me": The intensification of political polarization in Latin America and the Caribbean]. UNDP. https://www.undp.org/es/latin-america/blog/conmigo-o-en-mi-contra-la-intensificacion-de-la-polarizacion-politica-en-america-latina-y-el-caribe

- United Nations Development Programme. (2025, May 27). Jairo Acuña: "Los espacios para generar consensos son un antídoto contra la polarización" [Jairo Acuña: "Spaces for building consensus are an antidote to polarization"]. UNDP. https://www.undp.org/es/peru/noticias/-jairo-acuna-los-espacios-para-generar-consensos-son-un-antidoto-contra-la-polarizacion

- World Health Organization. (2012). WHO *QualityRights tool kit: Assessing and improving quality and human rights in mental health and social care facilities.* https://www.who.int/publications/i/item/9789241548410

- World Health Organization. (2019). *QualityRights materials for training, guidance and transformation.* https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

- World Health Organization. (2021a). *Comprehensive mental health service networks: Promoting person-centred and rights-based approaches.* https://www.who.int/publications/i/item/9789240025844

- World Health Organization. (2021b). *Guidance on community mental health services: Promoting person-centred and rights-based approaches.* https://www.who.int/publications/i/item/9789240025707

- World Health Organization. (2021c). *Supported living services for mental health: Promoting person-centred and rights-based approaches.* https://www.who.int/publications/i/item/9789240025820

- World Health Organization. (2021d). *Plan de acción integral sobre salud mental 2013–2030* [Comprehensive mental health action plan 2013–2030]. https://www.who.int/es/publications/i/item/9789240031029

- World Health Organization. (2022a). *Mental health atlas 2020. Member State Profile: Peru* https://cdn.who.int/media/docs/default-source/mental-health/-mental-health-atlas-2020-country-profiles/per.pdf?sfvrsn=7b9602c0_5

- World Health Organization. (2022b). *World mental health report: Transforming mental health for all.* https://www.who.int/publications/i/item/9789240049338. Retrieved October 9, 2026. World Health Organization. (2022c). Mental health and climate change: Policy brief. https://www.who.int/publications/i/item/9789240045125. Retrieved October 9, 2026.

- World Health Organization. (2025a). *Mental health atlas 2024*. https://www.who.int/publications/i/item/9789240114487

- World Health Organization Regional Office for Europe. (2025b). T*ransforming mental health through lived experience: Roadmap for integrating lived and living experience practitioners into policy, services and community.* https://www.who.int/europe/publications/i/item/WHO-EURO-2025-12307-52079-79927

- World Health Organization. (2026a, September 11). *Salud mental* [Mental health]. https://www.who.int/es/news-room/fact-sheets/detail/mental-health-strengthening-our-response

- World Health Organization. (2026b, October 9). Lived experience heard: Real voices, real change. https://www.who.int/publications/m/item/lived-experience-heard--real-voices--real-change

- World Health Organization. (2026c, October 9). Supporting the transition to community-based mental health and social care: Practical guide to the deinstitutionalization of psychiatric hospitals. https://www.who.int/publications/i/item/9789240124134

- World Health Organization, & Office of the United Nations High Commissioner for Human Rights. (2023). *Mental health, human rights and legislation: Guidance and practice. World Health Organization.* https://www.who.int/publications/i/item/9789240080737

